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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 21, 2022	2022_673672_0005	011005-21, 015636-21, 018396-21, 019309-21, 000106-22, 000401-22	Critical Incident System

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

JENNIFER BATTEN (672), CATHERINE OCHNIK (704957)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 14, 15, 16, 18 and 22, 2022

A Follow Up inspection (#2021_673672_0004) was conducted concurrently to this Critical Incident System Inspection. Findings of non-compliance were issued within that inspection report as well.

The following intake was completed during this Critical Incident System inspection:

One intake related to an alleged incident of resident to resident abuse.

One intake related to an alleged incident of visitor to resident abuse.

One intake related to an alleged incident of staff to resident abuse.

Two intakes related to resident falls with injury and significant changes in condition.

One intake related to an outbreak in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Public Health Consultants, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Recreation Aides (RAs), Physiotherapists (PT) and physio assistants (PTA), Dietary Aides (DAs), Housekeepers, Maintenance Workers, screeners and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Prevention and Abuse and Neglect, Infection Prevention and Control, Pain Management, Falls Prevention, Safe Food Handling and Serving Temperatures. The Inspector(s) also observed staff to resident and resident to resident care and interactions along with infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **7 WN(s)**
- **2 VPC(s)**
- **5 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 that all staff participated in the infection prevention and control program.

According to the Administrator, Public Health declared a resident home area to be in a suspected outbreak and staff were directed to follow contact and droplet precautions for identified residents who were possibly affected with the illness.

During observations conducted, the following infection prevention and control practices were observed:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- Open rolls of toilet paper were observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

- In multiple shared resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- PPE stations outside of multiple resident rooms who required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- Staff were observed putting on and/or taking off PPE items in an incorrect manner or sequence.

- Some resident bedrooms who required contact/droplet precautions to be implemented in order to enter were missing the required signage.

- Staff and essential caregivers were observed to be walking in the hallways while wearing PPE items such as gowns and gloves.

- Staff were observed exiting the home while still wearing their face shields and masks, without cleaning or changing the items upon exiting the home.

- Food items were observed sitting on PPE donning stations outside of resident bedrooms.

- Staff were observed assisting residents with personal care, such as repositioning, without wearing the required PPE items.

- Some Essential Visitors were observed to be resident bedrooms who required contact/droplet precautions to be implemented without wearing the required PPE items.

- Staff members were observed to not maintain physical distancing when not providing care to residents.

- Multiple staff members were observed to not have face shields/eye protection in place.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their masks or clean their eye protection following the provision of resident care.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, housekeeping and dietary staff, Associate Director of Care (ADOC), Director of Care (DOC) and the Administrator. [s. 229. (4)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #019 was protected from incidents of abuse.

A Critical Incident Report (CIR) was submitted to the Director related to an alleged incident of resident-to-resident abuse, which occurred between residents #018 and #019. The CIR indicated that residents #018 and #019 were found in resident #019's bedroom, exhibiting identified responsive behaviours. The CIR further indicated that residents #018 and #019 had a previous history and resident #018 had a further history of incidents which included identified exhibited responsive behaviours.

Review of resident #018's progress notes indicated a specified number of CIRs were submitted to the Director prior to the incident, related to resident #018's exhibited responsive behaviours. Following the incidents, resident #018 had several interventions implemented. Review of resident #018's plan of care indicated one of the identified interventions was no longer in place at the time of the incident with resident #019, despite resident #018's progress notes indicating they continued to exhibit identified responsive behaviours.

Residents #018 and #019 could not be interviewed about the incident due to a specified reason.

Failure to ensure resident #019 was protected from incidents of abuse by a resident could have resulted in the resident experiencing identified injuries.

Sources: Critical Incident Report; internal policy related to the prevention of resident abuse and neglect; internal investigation notes; resident #018's written plan of care, MDS Assessment and specified progress notes; resident #019's written plan of care, MDS Assessment and specified progress notes; interviews with RPN #134, the ADOC, DOC and Administrator. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that personal items were labelled, as required.

Observations conducted revealed there were multiple personal items in shared resident bathrooms and Spa rooms, such as used rolls of deodorant, hair combs, hairbrushes and razors which were not labelled as required with the resident's name.

During separate interviews, PSWs and the DOC verified the expectation in the home was for all personal items to be labelled with the resident's name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident's personal item, which could be unsanitary.

Sources: Observations conducted, interviews with PSWs and the DOC. [s. 37. (1) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #002 fell, a post-fall assessment was conducted, using a clinically appropriate instrument that was specifically designed for falls.

A specified CIS report indicated that resident #002 had a witnessed undocumented fall. On a later date, resident #002 was transferred to hospital and was found to have had an identified injury.

Clinical record review revealed post falls assessments were not completed between when the fall occurred to the resident's transfer to hospital. The internal policy related to the fall prevention and management program required that a post-fall assessment be completed by registered staff following any fall, using a specified report.

The licensee’s investigation notes showed that a registered staff member acknowledged that resident #002 had sustained a fall for which they did not complete a post falls assessment.

During an interview, ADOC verified that a post falls assessment had not been completed for resident #002 after their fall.

As a result of a post fall assessment not being completed, there was actual harm to resident #002, which led to a delay in resident #002 receiving treatment.

Sources: CIS report; the licensee’s investigation notes; internal policy related to the fall prevention and management program; resident #002’s progress notes, clinical record review, interview with ADOC. [s. 49. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 failed to ensure that when resident #002's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

A specified CIS report indicated that resident #002 had a witnessed undocumented fall. On a later date, resident #002 was transferred to hospital and was found to have had an identified injury.

Review of the progress notes indicated that resident #002 reported and exhibited both verbal and nonverbal signs and symptoms of pain. This led to the resident exhibiting identified responsive behaviours. Review of resident #002's health care record indicated the resident received identified interventions.

Review of resident #002’s plan of care indicated that following the fall, the resident sustained a significant change in status.

The licensee’s internal investigation notes indicated that staff members directly involved in resident #002’s care suspected the resident was in pain. The internal policy related to the pain management program stated pain assessments were to be completed and documented using a clinically appropriate assessment instrument specifically designed for that purpose. Clinical record review revealed pain assessments were not completed for resident #002 as required.

During an interview, the ADOC stated the expectation in the home was for pain assessments to be completed when a resident exhibited signs and symptoms of pain and verified resident #002 had complained of and exhibited symptoms of pain. The ADOC acknowledged that pain assessments had not been completed for resident #002 after their fall or at other identified times as directed within the internal policy related to the pain management program.

As a result of the lack of pain assessments, there was actual risk and actual harm to resident #002, as they continued to experience pain without intervention.

Sources: CIS report; the licensee’s internal investigation notes; internal policy related to the pain management program; resident #002’s progress notes and clinical record review; interview with the ADOC. [s. 52. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A CIR was submitted to the Director related to an alleged incident of resident-to-resident abuse, which occurred between residents #018 and #019. Review of the CIR indicated the Director had not been notified of the allegation within the legislated timeframe. Review of the after hours INFOLine documentation, internal incident report and residents #018 and #019's progress notes did not indicate the Director had been notified of the incident.

During an interview, the DOC indicated they were aware of the requirement for the Director to be immediately notified of any allegation of abuse of a resident by anyone that resulted in harm or risk of harm. The DOC further indicated all staff who worked in the home were provided with education on the prevention of resident abuse and neglect prior to working with residents and annually thereafter. The education provided included the directions for the Director to be immediately notified of every allegation of incidents of resident abuse and/or neglect. The DOC could not indicate why the Director had not been immediately notified of the alleged incident between residents #018 and #019 but verified the notification had not been completed as required.

Sources: Critical Incident Report; after hours INFOLine documentation; internal incident report; residents #018 and #019's progress notes and interview with the DOC. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who has reasonable grounds to suspect that the abuse of a resident has occurred, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that interventions were developed and implemented to assist residents and staff who were at risk of harm as a result of a resident's behaviours, including responsive behaviours.

A Critical Incident Report (CIR) was submitted to the Director related to an alleged incident of staff to resident abuse, which occurred between resident #003 and PSW #124. The CIR indicated that student #136 reported they observed PSW #124 abuse resident #003 during personal care. The CIR further indicated part of the allegation was unfounded but another part of the allegation was founded, for specified reasons. This was verified by the internal investigation notes.

Resident #003, student #136 and PSW #124 could not be interviewed during the inspection due to identified reasons.

During separate interviews, the DOC verified the allegation of abuse to resident #003 was substantiated. The DOC further indicated PSW #124 had not implemented interventions required when a resident exhibited responsive behaviours. The Administrator and DOC indicated that all staff members receive education related to the prevention of resident abuse and neglect and responsive behaviours.

Failure to ensure resident #003 was protected from incidents of harm when PSW #124 did not implement required interventions could have resulted in the resident experiencing specified injuries.

Sources: Critical Incident Report; internal policy related to the prevention of resident abuse and neglect; internal investigation notes; resident #003’s plan of care and progress notes; interviews with the DOC and Administrator. [s. 55. (a)]

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 interventions are developed and implemented to assist residents and staff who are at risk of harm as a result of a resident's behaviours, including responsive behaviours, to be implemented voluntarily.

Issued on this 22nd day of March, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JENNIFER BATTEN (672), CATHERINE OCHNIK (704957)
Inspection No. / No de l’inspection :	2022_673672_0005
Log No. / No de registre :	011005-21, 015636-21, 018396-21, 019309-21, 000106-22, 000401-22
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 21, 2022
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Taunton Mills 3800 Brock Street North, Whitby, ON, L1R-3A5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Daniel Kennedy

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

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 :

The licensee must be compliant with with s. 229 (4) of the LTCHA.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2. Conduct daily hand hygiene audits for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

3. Conduct daily audits of PPE donning/doffing and usage to ensure PPE is being utilized, donned and doffed as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

4. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the education, training and audits completed and make available for Inspectors, upon request.

5. All PPE caddies must be fully stocked and have appropriate PPE items in them.

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

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the infection prevention and control program.

According to the Administrator, Public Health declared a resident home area to be in a suspected outbreak and staff were directed to follow contact and droplet precautions for identified residents who were possibly affected with the illness.

During observations conducted, the following infection prevention and control practices were observed:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- Open rolls of toilet paper were observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and Spa rooms.

- In multiple shared resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- PPE stations outside of multiple resident rooms who required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- Staff were observed putting on and/or taking off PPE items in an incorrect manner or sequence.

- Some resident bedrooms who required contact/droplet precautions to be implemented in order to enter were missing the required signage.

- Staff and essential caregivers were observed to be walking in the hallways while wearing PPE items such as gowns and gloves.

- Staff were observed exiting the home while still wearing their face shields and masks, without cleaning or changing the items upon exiting the home.

- Food items were observed sitting on PPE donning stations outside of resident bedrooms.

- Staff were observed assisting residents with personal care, such as repositioning, without wearing the required PPE items.

- Some Essential Visitors were observed to be resident bedrooms who required contact/droplet precautions to be implemented without wearing the required PPE items.

- Staff members were observed to not maintain physical distancing when not providing care to residents.

- Multiple staff members were observed to not have face shields/eye protection in place.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their masks or clean their eye protection following the provision of resident care.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, housekeeping and dietary staff, Associate Director of Care (ADOC), Director of Care (DOC) and the Administrator.

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

Severity: There was actual risk of harm to the residents because of the potential for possible transmission of infectious agents due to the staff not participating in

the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread, as the IPAC related concerns were identified during observations throughout the home, and the areas of non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: A Compliance Order was issued to the licensee during Critical Incident System inspection #2021_715672_0004, on February 12, 2021, with a compliance due date of February 17, 2021 and was complied on April 15, 2021
. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 18, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 of the LTCHA.

Specifically, the licensee must:

1) Create and implement a plan to ensure that all residents are protected from incidents of abuse. Keep a documented record of the plan and make available to Inspectors upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #019 was protected from incidents of abuse.

A Critical Incident Report (CIR) was submitted to the Director related to an alleged incident of resident-to-resident abuse, which occurred between residents #018 and #019. The CIR indicated that residents #018 and #019 were found in resident #019's bedroom, exhibiting identified responsive behaviours. The CIR further indicated that residents #018 and #019 had a previous history and resident #018 had a further history of incidents which included identified exhibited responsive behaviours.

Review of resident #018's progress notes indicated a specified number of CIRs were submitted to the Director prior to the incident, related to resident #018's exhibited responsive behaviours. Following the incidents, resident #018 had several interventions implemented. Review of resident #018's plan of care indicated one of the identified interventions was no longer in place at the time of the incident with resident #019, despite resident #018's progress notes indicating they continued to exhibit identified responsive behaviours.

Residents #018 and #019 could not be interviewed about the incident due to a specified reason.

Failure to ensure resident #019 was protected from incidents of abuse by a resident could have resulted in the resident experiencing identified injuries.

Sources: Critical Incident Report; internal policy related to the prevention of resident abuse and neglect; internal investigation notes; resident #018's written plan of care, MDS Assessment and specified progress notes; resident #019's written plan of care, MDS Assessment and specified progress notes; interviews with RPN #134, the ADOC, DOC and Administrator.

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

Severity: There was actual harm and risk of harm to residents #003 and #019, which could have resulted in both physical and emotional injuries.

Scope: The scope of this non-compliance was isolated, as there was one incident of resident abuse and/or neglect inspected upon was founded.

Compliance History: Within the previous 36 months, a Voluntary Plan of Correction was issued to the licensee in Critical Incident System inspection report (Inspection #2020_715672_0011) on October 5, 2020. A second Voluntary Plan of Correction was issued to the licensee in Critical Incident System inspection report (Inspection #2021_875501_0021) on October 21, 2021.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 18, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,

(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Order / Ordre :

The licensee must be compliant with section s. 37 (1) (a) of the LTCHA.

Specifically, the licensee must:

1. Conduct bi-weekly audits of the resident home areas for a minimum period of four weeks. The audits are to include the tub and shower rooms, care trolleys and baskets, to ensure that all personal items are appropriately labelled with the resident's name. Keep a documented record of the audits completed and make available to Inspectors upon request.

Grounds / Motifs :

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

1. The licensee failed to ensure that personal items were labelled, as required.

Observations conducted revealed there were multiple personal items in shared resident bathrooms and Spa rooms, such as used rolls of deodorant, hair combs, hairbrushes and razors which were not labelled as required with the resident’s name.

During separate interviews, PSWs and the DOC verified the expectation in the home was for all personal items to be labelled with the resident’s name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident’s personal item, which could be unsanitary.

Sources: Observations conducted, interviews with PSWs and the DOC.

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

Severity: There was minimal risk of harm to the residents due to the potential for possible transmission of infectious agents caused by residents possibly using personal items which did not belong to them.

Scope: The scope of this non-compliance was widespread, as unlabelled personal items were located in multiple areas throughout the entire home.

Compliance History: a Voluntary Plan of Correction was issued to the licensee in Complaint inspection report (Inspection #2019_715672_0008), issued on August 22, 2019. A second Voluntary Plan of Correction was issued to the licensee in Critical Incident System inspection report (Inspection #2021_715672_0004) issued on February 12, 2021.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 18, 2022

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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must be compliant with sections s. 49 of the LTCHA.

Specifically, the licensee must:

1. Create and implement a plan to ensure that when residents fall, a post-fall assessment is conducted, using a clinically appropriate instrument, specifically designed for that purpose.

Grounds / Motifs :

1. The licensee has failed to ensure that when resident #002 fell, a post-fall assessment was conducted, using a clinically appropriate instrument that was specifically designed for falls.

A specified CIS report indicated that resident #002 had a witnessed undocumented fall. On a later date, resident #002 was transferred to hospital and was found to have had an identified injury.

Clinical record review revealed post falls assessments were not completed between when the fall occurred to the resident's transfer to hospital. The internal policy related to the fall prevention and management program required that a post-fall assessment be completed by registered staff following any fall, using a specified report.

The licensee's investigation notes showed that a registered staff member acknowledged that resident #002 had sustained a fall for which they did not

complete a post falls assessment.

During an interview, ADOC verified that a post falls assessment had not been completed for resident #002 after their fall.

As a result of a post fall assessment not being completed, there was actual harm to resident #002, which led to a delay in resident #002 receiving treatment.

Sources: CIS report; the licensee's investigation notes; internal policy related to the fall prevention and management program; resident #002's progress notes, clinical record review, interview with ADOC.

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

Severity: There was actual risk of harm to the residents from not being assessed using a clinically appropriate tool following every fall sustained.

Scope: The scope of this non-compliance was isolated, as only one resident involved in the inspection was affected.

Compliance History: Within the previous 36 months, non-compliance was observed to different areas of the legislation.
(704957)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 18, 2022

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 : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with sections s. 52 of the LTCHA.

Specifically, the licensee must:

1. Create and implement a plan to ensure that when residents express signs and symptoms of pain, they are assessed using a clinically appropriate instrument, specifically designed for that purpose.

Grounds / Motifs :

1. The licensee failed to ensure that when resident #002's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

A specified CIS report indicated that resident #002 had a witnessed undocumented fall. On a later date, resident #002 was transferred to hospital and was found to have had an identified injury.

Review of the progress notes indicated that resident #002 reported and exhibited both verbal and nonverbal signs and symptoms of pain. This led to the resident exhibiting identified responsive behaviours. Review of resident #002's health care record indicated the resident received identified interventions.

Review of resident #002's plan of care indicated that following the fall, the resident sustained a significant change in status.

The licensee's internal investigation notes indicated that staff members directly

involved in resident #002's care suspected the resident was in pain. The internal policy related to the pain management program stated pain assessments were to be completed and documented using a clinically appropriate assessment instrument specifically designed for that purpose. Clinical record review revealed pain assessments were not completed for resident #002 as required.

During an interview, the ADOC stated the expectation in the home was for pain assessments to be completed when a resident exhibited signs and symptoms of pain and verified resident #002 had complained of and exhibited symptoms of pain. The ADOC acknowledged that pain assessments had not been completed for resident #002 after their fall or at other identified times as directed within the internal policy related to the pain management program.

As a result of the lack of pain assessments, there was actual risk and actual harm to resident #002, as they continued to experience pain without intervention.

Sources: CIS report; the licensee's internal investigation notes; internal policy related to the pain management program; resident #002's progress notes and clinical record review; interview with the ADOC.

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

Severity: There was actual harm to resident #002, which resulted in the resident experiencing pain for a longer period of time, due to not being properly assessed using a clinically appropriate instrument designed for that purpose.

Scope: The scope of this non-compliance was isolated, as only one resident involved in the inspection was affected.

Compliance History: Within the previous 36 months, a Voluntary Plan of Correction was issued to the licensee in Critical Incident System inspection report (Inspection #2019_640601_0016), issued on August 22, 2019.

(704957)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Apr 18, 2022

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:

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

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 21st day of March, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

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