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
Jun 3, 2021	2021_715672_0018	002946-21	Complaint

Licensee/Titulaire de permis

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

2020 Fisher Drive Suite 1 Peterborough ON K9J 6X6

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

The Willows Estate Nursing Home
13837 Yonge Street Aurora ON L4G 3G8

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

JENNIFER BATTEN (672)

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): April 26, 27, 28, 29 and 30, 2021

The following intakes were completed during this inspection:

One intake related to a complaint received regarding allegations of resident neglect, staff to resident abuse, restraining of residents and IPAC practices in the home.

During the course of the inspection, Critical Incident System and Follow Up inspections were conducted concurrently.

During the Follow Up inspection, the following intake(s) were completed:

One intake conducted as a follow up to a previous Compliance Order issued to the home in inspection report #2021_715672_0002, related to the internal infection prevention and control program.

During the Critical Incident System inspection, the following intake(s) were completed:

One intake related to allegations of staff to resident abuse and medication administration practices occurring in the home.

One intake related to allegations of staff to resident abuse.

Within the Critical Incident System inspection, a finding of non-compliance under s. 24 (1) was noted and will be issued within this Complaint Inspection report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Acting Director of Care (ADOC), Nutrition Services Manager (NSM), Registered Dietitian (RD), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Care Aides (CAs), administration assistants, nursing assistant services manager (NASM), housekeepers, recreation aides, health screeners, maintenance workers, unit clerks, essential caregivers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Nutritional Care and Prevention of Resident Abuse and Neglect. The Inspector(s) also observed staff to resident and resident to resident care and interactions, along with infection control and medication administration practices in the home.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **7 WN(s)**
- **4 VPC(s)**
- **3 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. 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 an allegation of resident abuse was immediately reported to the Director.

A complaint was submitted to the Director regarding an alleged incident of staff to resident abuse, which indicated they observed PSW #117 push resident #009 onto a bed. The licensee was also informed of the allegation of staff to resident abuse by a staff member.

A Critical Incident Report was submitted to the Director related to an alleged incident of staff to resident abuse related to resident #004. The licensee was informed of the allegation of staff to resident abuse by the resident's friend via email. According to the email, resident #004 had been emotionally abused, as staff had teased, made fun of the resident and ignored the resident's request to go to the bathroom which caused the resident to soil themself.

Review of the internal investigation notes did not indicate a Critical Incident Report had been submitted to the Director, nor a phone call placed to the after-hours line. Residents #004 and #009's progress notes and health care records also did not indicate the Director had been notified of the alleged incident.

The Acting DOC indicated they had not submitted CIRs nor were phone calls placed to the after-hours line of the Director after they became aware of the allegations of staff to resident abuse, as they were unsure of the accuracy of the allegations.

Sources: Complaint submitted to the Director, Critical Incident Report related to resident #004, internal investigation notes, resident #009's progress notes and health care record and interview with the Acting DOC. [s. 24. (1)]

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 O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDMs were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Inspector observed resident #001 being assisted with their lunch meal by PSW #101. The PSW appeared to be aggressively assisting the resident while resident #001 appeared to be agitated and exhibiting identified responsive behaviours. PSW #101 was observed to continue to attempt to assist resident #001, raised their voice to the resident several times and spoke to the resident in an inappropriate manner. Inspector immediately reported the observations to the DOC, who returned to the RHA and questioned PSW #101 in the dining area. The PSW indicated the resident “always” reacted in the same manner and finished the meal while the resident continued to appear to be agitated and exhibited identified responsive behaviours.

Inspector observed resident #002 attempting to leave the resident home area. Resident was stopped by recreation aide #108, who softly pushed resident out of the way to place their body between the resident and the door, while holding/pulling the door closed tightly so that the resident could not exit. RA #108 attempted to explain to resident that they were not supposed to leave the RHA due to the outbreak. Resident #002 appeared to become quite agitated and began raising their voice. In response, RA #108 also raised their voice and stated "I told you, you can't leave. Go sit down. You're not leaving. You're not going through this door. Go sit down! Now!" RA #108's raised voice caught the attention of PSW #109, who came out of a resident's room to see what was going on and

approached resident #002 and RA #108. PSW #109 softly soothed the resident and let them leave. PSW #109 then explained to RA #108 they could not restrain the residents on the RHA, and they had spoken to the resident in an inappropriate tone of voice. Inspector immediately reported observations to the DOC, who indicated they would "look into it".

A complaint was submitted to the Director regarding an alleged incident of staff to resident abuse related to resident #009. According to the complainant, a staff member reported they had observed PSW #117 push resident #009 onto a bed. The licensee was informed of the allegation of staff to resident abuse by a staff member.

Review of the internal investigation notes, resident #009's progress notes and health care record did not indicate their SDM was notified of the alleged incident.

The DOC verified to Inspector that they had not notified resident #001 or #002's SDMs of the observed incidents. The Acting DOC verified they had not notified resident #009's SDM of the alleged incident of staff to resident abuse.

By not ensuring resident #001, #002 and #009's SDMs were notified of the incidents, residents were placed at risk of further incidents of resident abuse and/or neglect, due to their SDMs not being fully informed therefore unable to advocate on the resident's behalf.

Sources: Observations conducted, resident #001, #002 and #009's progress notes and health records, resident #009's internal investigation notes, interviews with PSWs #101 and #109, RA #108, BSO RPN, Acting DOC and DOC. [s. 97. (1) (b)]

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. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that prohibited devices such as sheets, wraps, tensors, or other types of strips were not used for other than therapeutic purposes and to restrain residents in the home.

Two complaints were submitted to the Director regarding alleged incidents of staff restraining residents in their bedrooms by stuffing towels in the top of the bedroom doors, to prevent the doors from being able to open. The complaints indicated that staff were attempting to restrain residents in their bedrooms due to an outbreak occurring in the home, but some of the residents were cognitively impaired and unable to follow the directions to remain isolated in their rooms. The complaints further indicated that on several occasions, staff had been also been unable to remove the towels from the doors therefore had to contact maintenance workers to assist with getting the resident’s bedroom doors opened.

Telephone interviews with the complainants and identified maintenance staff verified the information from the complaints. The maintenance worker indicated there were times when they had struggled to get the towels removed from the doorframes and came close to having to remove a door from the hinges in order to remove the restraint. Lastly, the complainants and identified maintenance staff indicated they were aware this practice

had occurred in the home over several weeks during the outbreak, but were unsure if/when it stopped, as none of them were currently working in the resident home areas.

PSWs #106, #109 and #129 verified that during the outbreak, staff attempted to prevent residents with cognitive impairment from leaving their bedrooms by placing towels between the doors and doorframes. PSWs #106, #109 and #129 indicated there were several instances when staff had to access resident's bedrooms through adjoining bathroom doors as the towels had become stuck and maintenance had to be contacted to assist. The Acting DOC indicated they were aware of the allegations and believed they had been informed when someone from the MOLTC called to ask questions about the practice. They further indicated that once they became aware of the allegations, they "asked a few staff members, but no one said they were doing it, so we closed the issue". There were no internal investigation notes and upon review, Inspector could not locate any documentation to indicate the home had been contacted by the MOLTC to discuss the complaints. The Acting DOC and Administrator indicated it was not an acceptable practice for staff to restrain residents in their bedrooms at any time or to use sheets, wraps, tensors, or other types of strips for other than therapeutic purposes.

By not conducting an internal investigation to ensure staff were not/did not restrain residents in their bedrooms or use sheets, wraps, tensors, or other types of strips for anything other than for therapeutic purposes, residents were placed at risk of being improperly restrained, which could have led to serious physical or emotional injuries.

Sources: Complaints received by the Director; interviews with complainants, identified maintenance staff, PSWs #106, #109 and #129, Acting DOC and Administrator. [s. 112.]

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 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #001 and #002 were fully respected and treated with courtesy and respect in a way that fully recognized their individuality and respected their dignity.

Inspector observed resident #001 being assisted with their lunch meal by PSW #101. The PSW appeared to be aggressively assisting the resident while resident #001 appeared to be agitated and exhibiting identified responsive behaviours. PSW #101 was observed to continue to attempt to assist resident #001, raised their voice to the resident several times and spoke to the resident in an inappropriate manner.

Inspector observed resident #002 attempting to leave the resident home area. Resident was stopped by recreation aide #108, who softly pushed resident out of the way to place their body between the resident and the door, while holding/pulling the door closed tightly so that the resident could not exit. RA #108 attempted to explain to resident that they were not supposed to leave the RHA due to the outbreak. Resident #002 appeared to become quite agitated and began raising their voice. In response, RA #108 also raised their voice and stated "I told you, you can't leave. Go sit down. You're not leaving. You're not going through this door. Go sit down! Now!" RA #108's raised voice caught the attention of PSW #109, who came out of a resident's room to see what was going on and approached resident #002 and RA #108. PSW #109 softly soothed the resident and let them leave. PSW #109 then explained to RA #108 they could not restrain the residents on the RHA, and they had spoken to the resident in an inappropriate tone of voice.

The Acting DOC and Administrator indicated it was not acceptable practices for staff to restrain residents on the RHAs or speak to residents inappropriately or in raised voices.

By not ensuring residents were fully respected and treated with courtesy and respect in a way that fully recognized their individuality and respected their dignity, residents were placed at increased risk of further incidents occurring in the home.

Sources: Observations conducted, interviews with RA #108, PSWs #101 and #109, Acting DOC and Administrator. [s. 3. (1) 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 residents are fully respected and treated with courtesy and respect in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.

WN #5: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's care was provided as specified in their plan.

Inspector observed resident #001 being assisted with their lunch meal in the converted dining area of the resident home area by PSW #101. The PSW appeared to be aggressively assisting the resident while resident #001 appeared to be agitated and exhibiting identified responsive behaviours. Resident #001's exhibited responsive behaviours affected the dining atmosphere for other residents during the meal, as several residents were complaining of the noise and resident #001 was noted to have poor intake of the meal to that point.

During separate interviews, PSW #101, RN #102 and the BSO RPN indicated resident #001 exhibited identified responsive behaviours during meals, therefore identified interventions were listed in the resident's plan of care for staff to implement. BSO RPN further indicated that when a resident exhibited identified responsive behaviour(s), staff were expected to leave the resident and reapproach later, possibly in a different manner and/or with a different staff member. Resident #001's current written plan of care indicated there were interventions for staff to implement to assist during meal services for identified reasons.

By not ensuring resident #001's plan of care was provided to the resident as was specified, the resident exhibited identified responsive behaviours.

Sources: Observations conducted, resident #001's written plan of care, interviews with PSW #101, RN #102, BSO RPN and DOC. [s. 6. (7)]

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 residents receive care as specified in their plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged incident of resident abuse or neglect was immediately investigated.

Inspector observed resident #002 attempting to leave the resident home area. Resident was stopped by recreation aide #108, who softly pushed resident out of the way to place their body between the resident and the door, while holding/pulling the door closed tightly so that the resident could not exit. RA #108 attempted to explain to resident that they were not supposed to leave the RHA due to the outbreak. Resident #002 appeared to become quite agitated and began raising their voice. In response, RA #108 also raised their voice and stated "I told you, you can't leave. Go sit down. You're not leaving. You're not going through this door. Go sit down! Now!" RA #108's raised voice caught the attention of PSW #109, who came out of a resident's room to see what was going on and approached resident #002 and RA #108. PSW #109 softly soothed the resident and let them leave. PSW #109 then explained to RA #108 they could not restrain the residents on the RHA, and they had spoken to the resident in an inappropriate tone of voice. Inspector immediately reported observations to the DOC.

On a later date, the DOC verified to Inspector that they had not followed up with RA #108 or started an internal investigation into the incident.

By not ensuring every alleged incident of resident abuse was investigated, residents were placed at risk of further incidents of resident abuse and/or neglect occurring.

Sources: Observations conducted; interviews with PSWs #101, #109, RA #108, BSO RPN and DOC. [s. 23. (1) (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 every alleged incident of resident abuse or neglect is immediately investigated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was not restrained by the use of barriers, locks or other devices from leaving any part of the home, including the grounds of the home or from entering part of the home generally accessible to other residents.

Inspector observed resident #002 attempting to leave the resident home area. Resident was stopped by recreation aide #108, who softly pushed resident out of the way to place their body between the resident and the door, while holding/pulling the door closed tightly so that the resident could not exit. RA #108 attempted to explain to resident that they were not supposed to leave the RHA due to the outbreak. Resident #002 appeared to become quite agitated and began raising their voice. In response, RA #108 also raised their voice and stated "I told you, you can't leave. Go sit down. You're not leaving. You're not going through this door. Go sit down! Now!" RA #108's raised voice caught the attention of PSW #109, who came out of a resident's room to see what was going on and approached resident #002 and RA #108. PSW #109 softly soothed the resident and let them leave. PSW #109 then explained to RA #108 they could not restrain the residents on the RHA.

BSO RPN indicated resident #002 had a known history of leaving the RHA for identified reasons. BSO RPN stated staff were supposed to discourage the resident from leaving, but if not successful, had interventions they could implement. During separate interviews, BSO RPN and the DOC indicated staff had received education related to dealing with residents who exhibit responsive behaviours and it was not an acceptable practice in the home to restrain residents from leaving any part of the home, even during an outbreak.

By not ensuring residents were not restrained by the use of barriers, locks or other devices from leaving any part of the home, including the grounds of the home or from entering part of the home generally accessible to other residents, they were placed at risk of experiencing feelings of anxiety, confusion and agitation.

Sources: Observations conducted, resident #002’s written plan of care, interviews with PSWs #101, #109, RA #108, BSO RPN and DOC. [s. 30. (1) 5.]

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 residents are not not restrained by the use of barriers, locks or other devices or controls (except under the common law duty described in section 36), from leaving a room or any part of the home, including the grounds of the home or from entering part of the home generally accessible to other residents, to be implemented voluntarily.

Issued on this 4th day of June, 2021

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)
Inspection No. / No de l’inspection :	2021_715672_0018
Log No. / No de registre :	002946-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 3, 2021
Licensee / Titulaire de permis :	0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership 2020 Fisher Drive, Suite 1, Peterborough, ON, K9J-6X6
LTC Home / Foyer de SLD :	The Willows Estate Nursing Home 13837 Yonge Street, Aurora, ON, L4G-3G8
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Matthew Riel

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

To 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, 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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with section s. 24. (1) of O.Reg. 79/10.

Specifically, the licensee must:

1. Ensure that all allegations of resident abuse are immediately reported to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that an allegation of resident abuse was immediately reported to the Director.

A complaint was submitted to the Director regarding an alleged incident of staff to resident abuse, which indicated they observed PSW #117 push resident #009 onto a bed. The licensee was also informed of the allegation of staff to resident abuse by a staff member.

A Critical Incident Report was submitted to the Director related to an alleged incident of staff to resident abuse related to resident #004. The licensee was informed of the allegation of staff to resident abuse by the resident's friend via email. According to the email, resident #004 had been emotionally abused, as

staff had teased, made fun of the resident and ignored the resident's request to go to the bathroom which caused the resident to soil themself.

Review of the internal investigation notes did not indicate a Critical Incident Report had been submitted to the Director, nor a phone call placed to the after-hours line. Residents #004 and #009's progress notes and health care records also did not indicate the Director had been notified of the alleged incident.

The Acting DOC indicated they had not submitted CIRs nor were phone calls placed to the after-hours line of the Director after they became aware of the allegations of staff to resident abuse, as they were unsure of the accuracy of the allegations.

Sources: Complaint submitted to the Director, Critical Incident Report related to resident #004, internal investigation notes, resident #009's progress notes and health care record and interview with the Acting DOC.

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

Severity: There was minimal risk to the residents by not ensuring the Director was informed of every allegation of incidents of resident abuse and/or neglect.

Scope: The scope of this non-compliance was considered to be a pattern, as two of three alleged incidents of resident abuse were affected.

Compliance History: Voluntary Plans of Correction were issued to the home, during a Complaint Inspection (#2019_684604_0018) on September 3, 2019, and Critical Incident System Inspection (#2019_643111_0015) on July 31, 2019.

(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 24, 2021

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Order / Ordre :

The licensee must be compliant with section s. 97. (1) (b) of O.Reg. 79/10.

Specifically, the licensee must:

1. Ensure that every residents' SDM is notified of any alleged, suspected or witnessed incident of abuse or neglect of the resident according to the legislative requirements. Keep a documented record of the notification within the internal investigation notes.

Grounds / Motifs :

1. The licensee failed to ensure that the resident's SDMs were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Inspector observed resident #001 being assisted with their lunch meal by PSW #101. The PSW appeared to be aggressively assisting the resident while resident #001 appeared to be agitated and exhibiting identified responsive behaviours. PSW #101 was observed to continue to attempt to assist resident

#001, raised their voice to the resident several times and spoke to the resident in an inappropriate manner. Inspector immediately reported the observations to the DOC, who returned to the RHA and questioned PSW #101 in the dining area. The PSW indicated the resident "always" reacted in the same manner and finished the meal while the resident continued to appear to be agitated and exhibited identified responsive behaviours.

Inspector observed resident #002 attempting to leave the resident home area. Resident was stopped by recreation aide #108, who softly pushed resident out of the way to place their body between the resident and the door, while holding/pulling the door closed tightly so that the resident could not exit. RA #108 attempted to explain to resident that they were not supposed to leave the RHA due to the outbreak. Resident #002 appeared to become quite agitated and began raising their voice. In response, RA #108 also raised their voice and stated "I told you, you can't leave. Go sit down. You're not leaving. You're not going through this door. Go sit down! Now!" RA #108's raised voice caught the attention of PSW #109, who came out of a resident's room to see what was going on and approached resident #002 and RA #108. PSW #109 softly soothed the resident and let them leave. PSW #109 then explained to RA #108 they could not restrain the residents on the RHA, and they had spoken to the resident in an inappropriate tone of voice. Inspector immediately reported observations to the DOC, who indicated they would "look into it".

A complaint was submitted to the Director regarding an alleged incident of staff to resident abuse related to resident #009. According to the complainant, a staff member reported they had observed PSW #117 push resident #009 onto a bed. The licensee was informed of the allegation of staff to resident abuse by a staff member.

Review of the internal investigation notes, resident #009's progress notes and health care record did not indicate their SDM was notified of the alleged incident.

The DOC verified to Inspector that they had not notified resident #001 or #002's SDMs of the observed incidents. The Acting DOC verified they had not notified resident #009's SDM of the alleged incident of staff to resident abuse.

By not ensuring resident #001, #002 and #009's SDMs were notified of the

incidents, residents were placed at risk of further incidents of resident abuse and/or neglect, due to their SDMs not being fully informed therefore unable to advocate on the resident's behalf.

Sources: Observations conducted, resident #001, #002 and #009's progress notes and health records, resident #009's internal investigation notes, interviews with PSWs #101 and #109, RA #108, BSO RPN, Acting DOC and DOC.

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

Severity: There was minimal risk of harm to the residents of further incidents of resident abuse and/or neglect occurring, due to their SDMs not being fully informed therefore unable to advocate on the resident's behalf.

Scope: The scope of this non-compliance was considered to be a pattern, as three of the incidents inspected upon were affected.

Compliance History: A Voluntary Plan of Correction was issued to the home during a Complaint Inspection (#2019_684604_0018) on September 3, 2019; and during a Critical Incident System Inspection (#2019_643111_0015) on July 31, 2019.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 24, 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

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. 112. For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:

1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Order / Ordre :

The licensee must be compliant with section s. 112 of O.Reg. 79/10.

Specifically, the licensee must:

1. Review this finding of non-compliance and re-educate all front line staff (PSWs, RPNs, RNs, Recreation and Maintenance Staff that prohibited devices such as sheets, wraps, tensors, or other types of strips are not to be used other than for therapeutic purposes in the home. Keep a documented record of the education completed and staff sign off to acknowledge they understood the material reviewed.

Grounds / Motifs :

1. The licensee has failed to ensure that prohibited devices such as sheets, wraps, tensors, or other types of strips were not used for other than therapeutic purposes and to restrain residents in the home.

Two complaints were submitted to the Director regarding alleged incidents of

staff restraining residents in their bedrooms by stuffing towels in the top of the bedroom doors, to prevent the doors from being able to open. The complaints indicated that staff were attempting to restrain residents in their bedrooms due to an outbreak occurring in the home, but some of the residents were cognitively impaired and unable to follow the directions to remain isolated in their rooms. The complaints further indicated that on several occasions, staff had been also been unable to remove the towels from the doors therefore had to contact maintenance workers to assist with getting the resident's bedroom doors opened.

Telephone interviews with the complainants and identified maintenance staff verified the information from the complaints. The maintenance worker indicated there were times when they had struggled to get the towels removed from the doorframes and came close to having to remove a door from the hinges in order to remove the restraint. Lastly, the complainants and identified maintenance staff indicated they were aware this practice had occurred in the home over several weeks during the outbreak, but were unsure if/when it stopped, as none of them were currently working in the resident home areas.

PSWs #106, #109 and #129 verified that during the outbreak, staff attempted to prevent residents with cognitive impairment from leaving their bedrooms by placing towels between the doors and doorframes. PSWs #106, #109 and #129 indicated there were several instances when staff had to access resident's bedrooms through adjoining bathroom doors as the towels had become stuck and maintenance had to be contacted to assist. The Acting DOC indicated they were aware of the allegations and believed they had been informed when someone from the MOLTC called to ask questions about the practice. They further indicated that once they became aware of the allegations, they "asked a few staff members, but no one said they were doing it, so we closed the issue". There were no internal investigation notes and upon review, Inspector could not locate any documentation to indicate the home had been contacted by the MOLTC to discuss the complaints. The Acting DOC and Administrator indicated it was not an acceptable practice for staff to restrain residents in their bedrooms at any time or to use sheets, wraps, tensors, or other types of strips for other than therapeutic purposes.

By not conducting an internal investigation to ensure staff were not/did not

restrain residents in their bedrooms or use sheets, wraps, tensors, or other types of strips for anything other than for therapeutic purposes, residents were placed at risk of being improperly restrained, which could have led to serious physical or emotional injuries.

Sources: Complaints received by the Director; interviews with complainants, identified maintenance staff, PSWs #106, #109 and #129, Acting DOC and Administrator.

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

Severity: There was actual risk of harm to the residents as they were placed at risk of being improperly restrained, which could have led to serious physical or emotional injuries.

Scope: The scope of this non-compliance was considered to be a pattern, as this practice was occurring on several resident rooms and multiple residents in the home were affected.

Compliance History: One or more areas of non-compliance were issued to the home within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 24, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3rd day of June, 2021

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