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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 28, 2021	2020_857129_0010 (A1) (Appeal\Dir#: DR# 148)	015132-20, 018970-20, 019361-20	Complaint

Licensee/Titulaire de permis

United Mennonite Home for the Aged
4024 Twenty-Third Street Vineland ON L0R 2C0

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

United Mennonite Home
4024 Twenty-Third Street Vineland ON L0R 2C0

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

Amended by TAMMY SZYMANOWSKI (Director) - (A1)(Appeal\Dir#: DR# 148)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001,CO#002.
The Director's review was completed on April 28, 2021.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 148.
A copy of the Director Order is attached.

Issued on this 28th day of April, 2021 (A1)(Appeal\Dir#: DR# 148)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by TAMMY SZYMANOWSKI (Director) - (A1)(Appeal/Dir# DR# 148)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 3, 4, 5, 6, 9, 10, 12, 13, 17, 18, 19, 20, 24, 25 and 26, 2020

The following intakes were inspected:

015132-20 related to visiting, abuse, nutritional care and retaliation

018970-20 related to visiting and discouraging reporting

019361-20 related to visiting, COVID-19 protocols and discouraging reporting

During the course of the inspection, the inspector(s) spoke with residents and residents' Substitute Decision Makers, Registered Practical Nurses, Registered Nurses, Dietary Aids, Food Service Manager, Program Manager, Environmental Services Manager, the Assistant Director of Care, the Director of Care and the Executive Director.

During this inspection the Inspector made resident observations, observed meal service, reviewed clinical documentation, reviewed licensee policies (related to: Visiting residents, Management of Complaints, Quality Improvement Program, Prevention of Abuse and Medical Services), reviewed Medical staff contracts, reviewed Complaint Records and

communication sent to family members.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Reporting and Complaints
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
12 WN(s)
7 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

s. 82. (4) The licensee shall enter into the appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3). O. Reg. 79/10, s. 82 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #011, resident #012 and resident #013 had admission physical examinations completed and resident #014, resident #015 and resident #016 had annual physical examinations completed.

Resident #011 (Admitted 2020) - Five Year Medical Record not completed. There were no progress notes written by the Physician, that would indicate an admission physical examination had been completed when they were reviewed on Nov. 19, 2020.

Resident #012 (Admitted 2020) - Five Year Medical Record not completed. There were no progress notes written by the Physician that would indicate an admission physical examination had been completed when they were reviewed on Nov. 19, 2020.

Resident #013 (Admitted 2020) - Five Year Medical Record not completed. There were no progress notes written by the Physician that would indicate an admission physical examination had been completed when they were reviewed on Nov.19, 2020.

Resident #014 (Admitted 2012) - Five Year Medical Record not completed. There were no progress notes written by the Physician that would indicate an annual physical examination had been completed for 2014 and 2016, when they were reviewed on Nov. 24, 2020.

Resident #016 (Admitted 2017) - Five Year Medical Record not completed. There were no progress notes written by the Physician that would indicate an annual physical examination had been completed for 2018 and 2019, when they were reviewed on Nov. 24, 2020.

Resident #015 (Admitted 2014) - Five Year Medical Record not completed. There were no progress notes written by the Physician that would indicate an annual physical examination had been completed for 2015, 2018 and 2019, when they were reviewed on Nov. 24, 2020.

Registered Nurse (RN) #114 said, "the Physician had not completed the Five-Year Medical Record form used by the home for an extended period".

The Executive Director (ED) and the Director of Care (DOC) said, they were unaware that the Physician had not completed the required admission and annual physical examinations for the identified residents or that the Physician had not been completing the Five Year Medical Record document use by the home.

The gaps in completing and documenting the required admission and annual physical examinations of residents increased the risk that medical issues or physical ailments of residents, would go unidentified and not managed.

Sources: Resident #011, #012, #013, #014, #015 and #016's Five Year Medical Records and progress notes, interviews with RN #114, the DOC and the ED. [s. 82. (1) (b)]

2. The licensee failed to ensure that the physician attended regularly at the home to provide services, including assessments for 128 residents.

The ED, DOC and a RN, confirmed that the sole Physician providing medical care to 128 residents had not entered the home to provide medical services, including assessment for approximately nine months.

A resident's Substitute Decision Maker (SDM) expressed concern that the resident had ongoing issues in three identified health areas, but the Physician had not been in the home to see the resident and address these issues.

The DOC acknowledged that the Physician visits the home on Wednesdays but does not enter the building.

A RN confirmed the Physician had not been in the home since the beginning of the pandemic. The RN explained, the Physician would alert them when they arrive at the home, staff would open the curtains on the ground floor level so the Physician could see the residents, staff would speak to the Physician on the telephone, the Physician would request registered staff complete chest assessments for residents and the Five-Year Medical form was completed offsite by the Physician.

The ED confirmed they were aware the Physician had not entered the home for an extended period and a documented plan for how medical services would be provided to residents under these circumstances was not in place.

Not having a Physician attend the home regularly to assess residents increased the risk that medical situations and conditions would go undiagnosed and not managed.

Sources: Interviews with an identified resident's SDM, the DOC, RN #112 and the ED. [s. 82. (1) (b)]

3. The licensee failed to enter into a written agreement under O. Reg 79/10, s. 83 with the Attending Physician.

The ED provided a copy of the Attending Physician Agreement which identified that the agreement was made on January 1, 2012, for a term of three years from that date.

The written agreement between the licensee and the Attending Physician expired on January 1, 2015 and there was not a current written agreement between the licensee and the Physician.

Sources: The ED and the Attending Physician Agreement. [s. 82. (4)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 148)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 001,002

WN #2: 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:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure resident #001, resident #009 and resident #010's right to receive visitors of their choice was fully respected and promoted.

i)The licensee failed to fully respect and promote resident #001's right to receive visitors of their choice when, the ED denied resident #001's Substitute Decision Marker (SDM) to make essential caregiver visits to the resident and when the home failed to take action to develop and implement current policies, procedures and protocols to facilitate caregiver visits.

In accordance with the Ministry of Long-Term Care's (MLTC) Visitor policy, effective September 9, 2020, the SDM notified the home on an identified date in

September 2020, that they were resident #001's essential caregiver.

In response to the caregiver's notification, the ED sent an e-mail to the essential caregiver denying the essential caregiver status and indicated that they had determined that resident #001 did not need an essential caregiver.

A document provided by the DOC indicated that resident #001's essential caregiver was granted that status on an identified date in October 2020.

The ED's denial of essential caregiver visits, resulted in resident #001 being prevented from having unrestricted access and supportive care from their essential caregiver for 41 days.

Sources: MLTC documents and policies, e-mail from the ED, an interview with the SDM and the ED.

ii) The licensee failed to fully respect and promote resident #009's right to receive visitors of their choice when, the home failed to take action related to a written request from the resident's SDM that they be allowed to make caregiver visits to the resident and when they failed to take action to develop and implement current policies, procedures and protocols to facilitate essential caregiver visits.

Resident #009 acknowledged that they wanted to have visits from their family.

In accordance with the MLTC Visitor policy, effective September 9, 2020, resident #009's SDM notified the home on an identified date in September 2020, that they requested to be the resident's essential caregiver.

The ED confirmed that the home's policy related to essential caregiver visits was not kept current or implemented until October 16, 2020.

The ED's failure to act on a request for caregiver visits, resulted in resident #009 being prevented from having unrestricted access and supportive care from their essential caregiver for 71 days.

Sources: MLTC documents and policies, interviews with resident #009, resident #009's SDM, the DOC and the ED.

iii) The licensee failed to fully respect and promote resident #010's right to receive visitors of their choice when, the home denied resident #010's SDM's written notification that they were the resident's essential caregiver, and when the home failed to develop current policies, procedures and protocols to facilitate essential caregiver visits.

In accordance with the Ministry of Long-Term Care's (MLTC) Visitor policy, effective September 9, 2020, resident #010's SDM notified the home, in writing, they were the resident's essential caregiver on an identified date in September 2020.

During an interview, documented by Inspector #581, the essential caregiver indicated that the ED had denied the notification of essential caregiver.

A document provided by the DOC confirmed the home had approved the essential caregiver for resident #010 on an identified date in October 2020.

The ED confirmed that the home's policy related to essential caregiver visits was not kept current or implemented until October 16, 2020.

The ED's denial of essential caregiver visits resulted in resident #010 being prevented from having unrestricted access and supportive care from their essential caregiver for 35 days.

Sources: MLTC documents and policies and interviews with resident #010's SDM, the DOC and the ED. [s. 3. (1) 14.]

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 and ensuring, every residents right to receive visitors of their choice is fully respected and promoted, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 failed to ensure that the care set out in resident #001's care plan related to an identified risk, was based on assessments completed by the Registered Dietitian (RD) and the Speech Language Pathologist (SLP).

An assessment of the identified risk completed by the RD on an identified date, verified they observed resident #001 to show signs of the risk. The RD identified three specific care interventions during the assessment to mange the risk. The resident's plan of care did not include the care interventions identified during the RD's assessment of the resident.

An assessment of the identified risk completed by the SLP on an identified date, included 10 specific care interventions to manage the risk. The resident's plan of care did not include the care interventions identified during the SLP's assessment of the resident.

The Assistant Director of Care (ADOC) acknowledged that the residents' care plan did not contain a care focus related to the identified risk and did not include interventions identified following assessments by the RD and the SLP to manage the risk.

The failure to ensure that resident #001's care plan was based on assessments by the RD and the SLP, increased the risk that the resident would experience health issues related to the risk.

Sources: Resident #001's care plan, progress notes, Swallowing Recommendation document and an interview with the ADOC. [s. 6. (2)]

2. The licensee failed to ensure that resident #001 received nutritional care as set out in the plan of care.

Observations made during noon meal on November 3, 2020, confirmed that resident #001 did not receive three identified care interventions as directed on the Dietary Kardex/Choice Sheet for that day, as well as in the care plan and in progress notes documented by the RD.

Observations made during the noon meal on November 13, 2020, confirmed resident #001 was served an identified disliked entrée, and did not receive two specific care interventions as directed on the Dietary Kardex/Choice Sheet for that day, as well as in the care plan and in progress notes documented by the RD.

Observations made during the noon meal on November 17, 2020, confirmed resident #001 was not provided a specific care intervention as directed in the SLP's swallowing assessment.

The Assistant Director of Care (ADOC) confirmed resident #001 was to have received three identified care interventions that were not received during the periods of observation. Dietary Aid #103 confirmed that resident #001 did not receive two identified interventions on November 3, 2020.

Registered Practical Nurse (RPN) #109 confirmed that based on the recommendation of the SLP, resident #001 was to receive an identified intervention during meals.

Failure of staff to provide care interventions identified by the RD and the SLP increased the risk that the resident would experience health issues related to an identified risk and jeopardized the nutritional goals of the resident.

Sources: Resident #001's care plan, progress notes made by the RD, Dietary Kardex/Choice Sheet. Swallowing Recommendation document and interviews with the ADOC, Dietary Aide and RPN. [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 and ensuring the care set out in the plan of care is based on an assessment of the resident, the needs and preferences of that resident and the care set out in the resident's plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 12. s. 12. Every licensee of a long-term care home shall ensure that there is an organized program of medical services for the home. 2007, c. 8, s. 12.

Findings/Faits saillants :

1. The licensee failed to ensure that there was an organized program of medical services for the home.

The ED and Medical Services outline information provided, verified that no policies, procedures, protocols or monitoring activities had been developed to ensure the there was an organized program for the delivery of medical services to residents.

The ED did not ensure there was a plan in place for the provision of medical care to residents when there was a change in the delivery of those services. The Physician who acted as both the Attending Physician for 128 residents and the

Medical Director, informed the ED they would not be entering the home. The Physician had not entered the home for approximately nine months and the ED confirmed they were unable to provide a plan of how medical services were to be provided under those circumstances.

The ED did not ensure policies, procedures and monitoring activities were in place to ensure an objective identified in the Medical Care Program Outline, “to provide medical services that meet the requirements of the Ministry Legislation 2007", was attained. As a result, five areas of non-compliance with the requirements identified in Ontario Regulation 79/10, related to medical care and services were identified.

The ED took no action when the contractual obligations of the Attending Physician/Medical Director had not been met. The ED said they were unaware that admission and annual physical examinations of residents were not completed, and the Medical Director had not attended any of the four Professional Advisory Committee meetings held in 2019.

The ED confirmed there was no policy, procedure or monitoring activities developed to guide the implementation of the dual role of Attending Physician/Medical Director. Documents provide by the home indicated the Medical Director acted in an administrative supervisory role to the Attending Physician, however, no action was taken to ensure services identified as the responsibility of the Attending Physician were provided to the residents.

The ED confirmed that the Medical Director/Attending Physician had not completed any continuous quality improvement activities related to medical care provided to residents or administrative medical services activities. The program of Medical Services was not included in the home's quality improvement and utilization review system.

The failure of the ED to ensure there was an organized program of Medical Services, through the develop and implementation of policies, procedures, protocols and monitoring activities related to medical care provided to residents and administrative medical services, resulted in residents not having received legislated medical care.

Sources: Attending Physician Agreement, Medical Director Agreement, Medical Care Program Outline (dated Jun. 2004 with a revised date of Sept. 2017),

residents' Five-Year Medical Forms and progress notes, Continuous Quality Improvement documents and interview with the ED. [s. 12.]

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 and ensuring that there is an organized program of medical services for the home, to be implemented voluntarily.

WN #5: 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 failed to ensure that a witnessed incident of physical abuse of an identified resident by PSW staff, that was reported to the Director of Care, was investigated.

An identified resident's SDM contacted the Ministry of Long-Term Care (MLTC) and indicated that they had reported a witnessed incident of physical abuse to DOC #113 on an identified date in 2020, and had not heard any information from the home about the incident.

A review of the Complaint Record indicated that there was no documentation of actions taken related to the reported allegation and no documentation that indicated the allegation had been investigated.

The ADOC verified the Complaint Record did not provide evidence that the incident was
investigated, and they were unable to provide any other documentation related to an investigation of the incident.

The failure of the home to investigate a witnessed incident of physical abuse of a resident increased the risk that any injuries the resident sustained would go untreated and staff may continue to demonstrate abusive behavior toward residents.

Sources: Home's Complaint Record and interviews with a resident's SDM and ADOC. [s. 23. (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 and ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of or that is reported, is immediately investigated, to be implemented voluntarily.

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.
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, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee failed to ensure that a witnessed allegation of physical abuse of resident #001 by PSW staff was reported to the Director.

An e-mail sent by DOC #113 on an identified date in 2020, to the Executive Director (ED) and the ADOC confirmed that DOC #113, the ED and the ADOC were aware of the allegation of physical abuse of an identified resident.

A review of the home's record of complaints verified that the allegation of abuse was documented in the home's Complaint Record.

The ADOC confirmed they were aware of the allegation, said that "incident was a reportable incident" and confirmed they had not submitted a Critical Incident Report to notify the Director of the incident.

A review of the Critical Incident Report system confirmed that the home had not submitted notification to the Director that the home received a witnessed allegation of physical abuse of an identified resident.

Sources: Written communication from DOC #113, the home's Complaint Record, Critical Incident System and interview with the ADOC. [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 and ensuring that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred shall 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 LTCHA, 2007 S.O. 2007, c.8, s. 26. Whistle-blowing protection

Specifically failed to comply with the following:

s. 26. (1) No person shall retaliate against another person, whether by action or omission, or threaten to do so because,
(a) anything has been disclosed to an inspector; 2007, c. 8, s. 26 (1).
(b) anything has been disclosed to the Director including, without limiting the generality of the foregoing,
(i) a report has been made under section 24, or the Director has otherwise been advised of anything mentioned in paragraphs 1 to 5 of subsection 24 (1),
(ii) the Director has been advised of a breach of a requirement under this Act, or
(iii) the Director has been advised of any other matter concerning the care of a resident or the operation of a long-term care home that the person advising believes ought to be reported to the Director; or 2007, c. 8, s. 26 (1).
(c) evidence has been or may be given in a proceeding, including a proceeding in respect of the enforcement of this Act or the regulations, or in an inquest under the Coroners Act. 2007, c. 8, s. 26 (1).

s. 26. (5) None of the following persons shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c):
1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract described in section 110. 2007, c. 8, s. 26 (5).
2. If the licensee or the person who manages the home is a corporation, an officer or director of the corporation. 2007, c. 8, s. 26 (5).
3. In the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129. 2007, c. 8, s. 26 (5).
4. A staff member. 2007, c. 8, s. 26 (5).

Findings/Faits saillants :

1. The licensee failed to ensure no person retaliated against an identified person when that person disclosed to Inspectors that they had concerns about the care that was being provided to a resident and concerns about visiting a resident.

An identified person told an Inspector, that they had concerns about visiting a resident. When an Inspector contacted the ED, the ED made several comments about the identified person contacting the Ministry.

The identified person told another Inspector, they felt the home had treated them differently because they had previously complained to the Ministry and they considered this retaliation.

At the time of this inspection the ED disclosed they were in the process of determining actions that could be taken against the identified person because of the risks they believed this person posed. The results of those intended actions would have had a negative effect for an identified resident and the ED indicated they were aware of the effect the actions would have. A review of the reasons the ED provided for taking such action indicated that those reasons posed no risk to the home or to a resident.

The actions the ED intended to take, were not based on any reasonable or substantial risks to the home or a resident but would have had a negative impact on a resident.

Sources: MLTC Complaint Intake documents, interview with an identified person and the ED. [s. 26. (1) (a)]

2. The licensee failed to ensure that the ED did not do anything that discouraged, was aimed at discouraging or that had the effect of discouraging a person from disclosing anything to an Inspector.

Family members spoke to MLTC Inspectors about their concerns related to resident care and visitor issues in the home.

After the ED had been made aware that the MLTC had received concerns from family members, they sent an e-mail to all family members on September 19, 2020. In the e-mail the ED wrote; "Equally, it saddens us that through all our efforts, some family members saw fit to complain to the Ministry that we were deliberately not permitting them to visit and somehow stopped the resident from the right to have visitors. These family members in my view fail to see the bigger picture of keeping their loved one safe and keeping the other residents safe".

A family member spoke to an Inspector and told them; “the e-mail from the ED

made them feel like the families were the enemy, because they spoke with Inspectors".

A family member spoke to an Inspector and told them they felt; "the e-mail sent by the ED basically stated that families do not have the right to complain".

A family member spoke to an Inspector and told them that after the ED communication to families, they were made aware that other family members suspected the ED was speaking about them.

The ED was unable to explain their purpose or intent when they included the information about family members complaining to the Ministry in a communication to all family, other than to respond that it was "frank, honest information".

The ED's comments communicated disapproval and unhappiness that family members had requested the assistance of MLTC Inspectors to resolve their issues of concern. These comments increased the risk that other family members would be discouraged about communicating their concerns to Inspectors.

Sources: E-mail from ED to family members, MLTC Intake documents, family member interviews and interview with the ED. [s. 26. (5) 4.]

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 and ensuring that no person shall retaliate against another person whether by action or omission, or threaten to do so because anything has been disclosed to an inspection and that a staff member shall not do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from reporting anything to an inspector, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the documented record of complaints, included the required information.

A review of an identified Complaint Record indicated the home was made aware of five incidents of concern brought to the attention of DOC #113 by a family member.

The Complaint Record maintained by the home did not include the type of action taken to resolve the complaints, including the date of the action; time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

The ADOC acknowledged that they were unable to provide documentation to verify the type of action taken to resolve the complaints, including the date of the action; time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response.

Sources: Home’s Complaint Log and interview with the ADOC. [s. 101. (2)]

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 and ensuring that the documented record of complaints includes the type of action taken to resolve the complaint, including the date of the action; time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the written procedures for initiating complaints and how the licensee deals with complaints were complied with for an identified complaint.

LTCHA s. 21 requires the licensee to ensure there are written procedures for initiating complaints to the licensee and for how the licensee deals with complaints.

DOC #113 initiated a Complaint Record, for complaints related to six aspects of the provision of care for an identified resident.

The Complaint Record confirmed staff did not comply with the home's policy and procedure "Lodging Complaints", which directed staff to document the required information on the Complaint Record. The required documentation included actions taken to resolve the issues, any follow-up actions required, the complainant’s reaction to the outcome and Department Manager and ED signature and the date the document was signed.

The ADOC acknowledged the Complaint Record did not include documentation of the actions taken to resolve the issues, any follow-up actions required and the complainant’s reaction to the outcome.

The ADOC also acknowledged that the Complaint Record had not been signed and dated by the Department Manager or the ED.

Sources: Lodging Complaints policy, Complaint Record and interview with ADOC. [s. 8. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee failed to ensure that an Acute Respiratory Disease outbreak declared by Public Health was immediately reported to the Director.

The licensee contacted Public Health authorities to alert them of a potential disease outbreak on September 12, 2020. Following a review of information provided by the licensee, Public Health declared an Acute Respiratory Disease outbreak on September 13, 2020.

A Critical Incident System report and the DOC confirmed that the home notified the Director three days after the outbreak had been declared by Public Health.

Sources: Critical Incident System report #2951-000008-10 and interview with the DOC. [s. 107. (1) 5.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 214. Medical Director

Specifically failed to comply with the following:

s. 214. (1) Every licensee of a long-term care home shall enter into a written agreement with the Medical Director for the home that provides for at least the following:
1. The term of the agreement. O. Reg. 79/10, s. 214 (1).
2. The responsibilities of the licensee. O. Reg. 79/10, s. 214 (1).
3. The responsibilities or duties of the Medical Director under clause 72 (3) (b) of the Act, as set out in subsection (3). O. Reg. 79/10, s. 214 (1).

Findings/Faits saillants :

1. The licensee failed to ensure there was a written agreement with the Medical Director.

The ED provided a copy of the Medical Director Agreement which identified that the agreement was made on January 1, 2012, for a three-year term following that date.

The written agreement between the licensee and the Medical Director expired on January 1, 2015 and there was not a current written agreement between the licensee and the Medical Director.

Sources: The ED and the Medical Director Agreement. [s. 214. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure the quality improvement and utilization review system was ongoing through 2019/2020 and interdisciplinary when the system did not include medical services.

The licensee's Continuous Quality Improvement (CQI) Program policy set out a process that each Department Head/Manager must follow. The process included the identification of areas to be audited, the development of annual CQI plans, the completion of scheduled audits, the evaluation of any actions taken to improve quality, reports to be submitted monthly to the Executive Director (ED) and reviewed at the CQI Committee.

The licensee's program was not ongoing through 2019, when records reviewed, and the ED confirmed that the Administrative Department had not developed an annual CQI plan or completed the required Operational and Organizational audits identified in 2019.

The licensee's program was not ongoing through 2020, when records reviewed, and the ED confirmed the Administrative Department had not developed an annual CQI plan for 2020 or completed the required Operational or Organizational audits in 2020. The ED was unable to provide evidence that they had reviewed the monthly audits submitted by Department Head/Managers and that the home had held any CQI committee meetings to review home wide quality activities between January and December 2020. The ED confirmed they had not made any modifications to the CQI program requirements or processes for 2020.

The licensee's program was not ongoing when the DOC and records reviewed, confirmed that they had not completed the required audits for 2020, related to the Nursing Department.

Records reviewed confirmed that medical services were not part of the CQI system, when it was identified that the system did not contain any quality auditing activities related to medical services. The ED confirmed that the Medical Director had not submitted evidence that they had completed any CQI activities in 2019 or 2020.

Sources: CQI Reports submitted for 2019 and 2020, Continuous Quality Program Policy, Departmental auditing schedules, interviews with the ED and DOC. [s. 228. 2.]

Issued on this 28th day of April, 2021 (A1)(Appeal/Dir# DR# 148)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by TAMMY SZYMANOWSKI (Director) - (A1)(Appeal/Dir# DR# 148)
Inspection No. / No de l'inspection :	2020_857129_0010 (A1)(Appeal/Dir# DR# 148)
Appeal/Dir# / Appel/Dir#:	DR# 148 (A1)
Log No. / No de registre :	015132-20, 018970-20, 019361-20 (A1)(Appeal/Dir# DR# 148)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 28, 2021(A1)(Appeal/Dir# DR# 148)
Licensee / Titulaire de permis :	United Mennonite Home for the Aged 4024 Twenty-Third Street, Vineland, ON, L0R-2C0
LTC Home / Foyer de SLD :	United Mennonite Home 4024 Twenty-Third Street, Vineland, ON, L0R-2C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Walter Sguazzin

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 United Mennonite Home for the Aged, 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

(A1)(Appeal/Dir# DR# 148)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,

(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination;

(b) attends regularly at the home to provide services, including assessments; and

(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

(A1)(Appeal/Dir# DR# 148)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 002 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination;
(b) attends regularly at the home to provide services, including assessments; and
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
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 28th day of April, 2021 (A1)(Appeal/Dir# DR# 148)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by TAMMY SZYMANOWSKI (Director) - (A1)(Appeal/Dir# DR# 148)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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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

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Service Area Office / Bureau régional de services : Hamilton Service Area Office