Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: January 8, 2025

Inspection Number: 2024-1432-0008

Inspection Type:
Complaint
Critical Incident

Licensee: 955464 Ontario Limited

Long Term Care Home and City: Millennium Trail Manor, Niagara Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, December 13, December 16-17, December 19-20, December 23-24, December 27, and December 30, 2024

The following Critical Incident (CI) intake(s) were inspected:

- Intake #00120333/CI #2948-000027-24 - related to the prevention of abuse and neglect
- Intake #00120545/CI #2948-000029-24 - related to the prevention of abuse and neglect
- Intake #00121099/CI #2948-000030-24 - related to the prevention of abuse and neglect
- Intake #00124224/CI #2948-000038-24 - related to the prevention of abuse and neglect
- Intake #00124997/CI #2948-000040-24 - related to the prevention of abuse and neglect
- Intake #00126175/CI #2948-000041-24 - related to the prevention of abuse and neglect
- Intake #00127047/CI #2948-000042-24 - related to the prevention of abuse and neglect

- Intake #00132012/CI #2948-000049-24 - related to falls prevention and management
- Intake #00121897/CI #2948-000031-24 - related to falls prevention and management
- Intake #00132375 - complaint related to the prevention of abuse and neglect and plan of care

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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.

A) The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary
The plan of care for a resident stated that a specific number of staff must be present at all times during care. It was noted on separate occasions that staff entered the resident's room to provide care without the appropriate number of staff present.

During an investigation, staff confirmed that they provided care to the resident without the appropriate number of staff present. Management confirmed that the staff did not comply with a resident's plan of care.

There was risk to a resident's safety when staff members failed to comply with the resident's plan of care by having the appropriate number of staff present.

Sources: A resident's clinical records; investigation notes; the home's camera footage; and an interview with management.

B) The licensee failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in their plan of care.

Rationale and Summary
A resident required assistance by staff with the use of an assistive device. The resident's plan of care also indicated that a specified number of staff always be present when providing care and indicated that care be provided by specified staff members only.

On a specified date, a resident transferred onto their assistive device and requested staff assistance, care was not provided by the specified staff members or with the appropriate number of staff present.

Staff stated that the expectation was for staff to refer to the appropriate staff members to provide care and acknowledged that the specified staff members were not referred to when the resident requested assistance.

Failure to ensure that care was provided with the specified staff members and the appropriate number of staff as per a resident's plan of care put the resident's safety and well-being at risk.

Sources: Clinical records for a resident; the home's investigation; interview with staff and management.

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the policy "Promote Zero Tolerance of Abuse and Neglect: Investigations and Consequences" was complied with when a resident was verbally abused by a staff member.

Rationale and Summary

It was reported by a resident's Power of Attorney (POA) that a staff member verbally abused a resident on a specified date. The home's investigation and an interview with management confirmed that staff-to-resident verbal abuse was founded.

It was also confirmed that there were no remedial actions taken with the staff member as per the policy “Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences” to promote zero tolerance of abuse. The policy stated corrective action such as discipline and education would be implemented as

necessary at the completion of the investigation.

According to an interview with management, the discipline and education was not completed for the staff member.

Failure to comply with the "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" policy put residents at risk of future incidents of abuse.

Sources: A resident's clinical records; a CI report; interview with staff; home's investigation notes; policy "Zero Tolerance of Abuse and Neglect Program"; policy "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences".

WRITTEN NOTIFICATION: Orientation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 3.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

A) The licensee has failed to ensure that all staff at the home had received training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary
On a specified date, staff provided a resident with assistance with care, during which the resident alleged abuse occurred.

Prior to starting work at the long-term care home, agency staff members were not oriented and trained on the home's policy "Zero Tolerance of Resident Abuse and Neglect Program", dated November 2023. As per the policy, staff including agency and contracted positions required orientation and annual training on the policy and attestation of completing and understanding the policy.

Staff confirmed training was not provided to agency staff regarding the home's policy. Management acknowledged that they did not have training attestation records for those staff members on file, and confirmed the required training was not provided.

There was a risk that agency staff were not familiar with the home's policy to promote zero tolerance of abuse and neglect when they did not receive orientation training as required.

Source: Agency staff training records; a resident's clinical record; the home's investigation notes; interviews with management and staff; the home's "Zero Tolerance of Resident Abuse and Neglect Program", last reviewed November 2023.

B) The licensee has failed to ensure that staff received orientation training on the home's policy to promote zero tolerance of abuse and neglect of residents before performing their responsibilities.

Rationale and Summary
A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to allegations that a staff member was rough with multiple residents during care. Management acknowledged that the staff member did not complete their orientation training related to prevention of abuse and neglect of residents when they began working at the long-term care home (LTCH).

Failure to ensure a staff member received the required orientation training prior to

providing resident care posed a risk of staff not understanding their responsibilities as set out in the home's policies.

Sources: Staff employment file; CIS report; interview with management.

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that a resident had a falls risk assessment completed when they were identified as a falls risk.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that a falls risk assessment was completed, on admission or for a resident with multiple falls, as appropriate, and must be complied with.

Specifically, staff did not comply with the policy "Falls Prevention and Management Program" last reviewed January 2022, which was included in the licensee's Falls Prevention and Management Program.

Rationale and Summary
When a resident was admitted to the home, a falls risk screening indicated the resident was a risk for falls and that a comprehensive falls assessment needed to be completed.

During the resident's stay in the home, they sustained multiple falls. A review of their clinical record showed no documentation related to a falls risk assessment being completed during their stay in the home.

The home's Falls Prevention and Management Program policy stated to screen all residents on admission or with a change in condition that could potentially increase the resident's risk of falls/falls injury and to refer to the falls risk assessment. It also indicated under post-fall management to complete a falls risk assessment, as clinically indicated for any fall with serious injury or a resident with multiple falls, as appropriate. The falls risk assessment tool included in the policy was the Falls Risk Assessment Tool (FRAT).

Management reviewed the resident's electronic clinical record and stated they could not find the falls risk assessment. They stated when the resident was admitted, the home was in the process of implementing a new assessment tool for falls. They stated the resident's falls risk assessment was not done and was lost during the transition phase.

There was risk that a resident would not have the appropriate falls interventions in place when they did not have a falls risk assessment completed.

Sources: A resident's clinical record; a resident's physical chart; the home's Falls Prevention and Management Program policy, last reviewed January 2022; interview with management.

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following

interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The home has failed to ensure that the pain management program was followed for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a pain management program to identify pain in residents and manage pain, and that it was complied with.

Specifically, staff did not comply with the "Pain Identification and Management" policy.

Rationale and Summary
Staff were made aware of concerns related to a resident's skin integrity and pain management. During an initial skin assessment of the resident's skin impairment, they exhibited increased pain when the impairment was manipulated. The home's pain management program required staff to assess a resident's new pain using a comprehensive pain assessment, to capture factors such as location of pain, provoking factors, radiation of pain, timing and effect on the resident's quality of life, which inform pain management that may be required.

Management acknowledged that a comprehensive pain assessment should have been completed when the resident exhibited pain during the skin assessment and that it was not completed by staff until a later date.

Failure to complete a comprehensive pain assessment at the onset of new pain associated with an area of skin impairment may have delayed staff's understanding of the nature of the resident's pain.

Sources: A resident's clinical record; policy "Pain Identification and Management" (reviewed January 2022); interviews with management and staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

A) The licensee has failed to ensure that a resident received a skin and wound assessment using a clinically appropriate assessment tool when they exhibited altered skin integrity.

Rationale and Summary
On a specified date, staff documented that a resident had new altered skin integrity. A review of the resident's clinical record showed no documentation of a skin and wound assessment for the area of altered skin integrity.

The home's Wound Care Management policy indicated a resident exhibiting altered skin integrity would receive a skin assessment by staff using a clinically appropriate assessment instrument.

Staff stated skin and wound assessments are documented in the electronic clinical record. They reviewed the resident's electronic clinical record and confirmed a skin and wound assessment was not completed for the resident's area of altered skin

integrity.

There was risk of worsening skin integrity when a skin and wound assessment was not completed for a resident.

Sources: A resident's clinical record; the home's Wound Care Management policy dated October 2023; interview with staff.

B) The licensee has failed to ensure that a resident received a skin and wound assessment using a clinically appropriate assessment tool promptly when they exhibited altered skin integrity.

Rationale and Summary
On a specified date, staff documented a resident had new altered skin integrity. A review of the resident's clinical record did not show a skin and wound assessment being completed until a later date. On that date, an initial skin and wound assessment was completed, which identified the altered skin integrity.

The home's Wound Care Management policy indicated staff must promptly assess all resident's exhibiting altered skin integrity on initial discovery and use the clinically appropriate assessment tool for skin impairments.

Staff stated that the skin and wound assessment for the resident was not completed when they identified it. They also stated that skin and wound assessments are to be completed as soon as possible after new altered skin integrity is identified.

There was risk of worsening skin integrity when a skin and wound assessment was not completed promptly for resident.

Sources: A resident's clinical record; the home's Wound Care Management policy dated October 2023; interview with staff.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. The response provided to a person who made a complaint shall include,

i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

ii. an explanation of,

A. what the licensee has done to resolve the complaint, or

B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and

iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that when they received verbal complaints concerning the care of residents, that their responses included the required information under this legislative reference.

Rationale and Summary

A) A resident's family contacted management on a specified date with several concerns. The home's complaint procedure required the department manager to provide the complainant a written response at the conclusion of the investigation, including the requirements listed under s. 108 (1) 3., unless the verbal complaint was resolved within 24 hours. The investigation into the concerns took place over a timeframe greater than 24 hours.

Management acknowledged that a written response with the required information was not provided to the complainant at the conclusion of the investigation. Further, they could not substantiate that the required contact information was provided verbally when the complainant was contacted and informed of the conclusion of the investigation.

Sources: A resident's clinical record; policy "Complaint and Customer Service" (reviewed April 2022); and interview with management.

Rationale and Summary
B) On a specified date, multiple residents reported care concerns to staff. Staff obtained statements from the residents and reported to the on-call manager to initiate the investigation process. When a resident's substitute decision maker (SDM) was notified of the concerns, they requested to be made aware of the outcome of the investigation.

The home's complaint procedure required the department manager to provide complainants a written response at the conclusion of the investigation, including the requirements listed under s. 108 (1) 3. Management acknowledged that neither a written or verbal response with the required information was provided to the complainants or to the resident's SDM at the conclusion of the investigation.

Failure to provide a response to the complainants posed a risk of communication breakdown between the LTCH and complainants and may have led to distress when residents and an SDM were not made aware of the outcome of the investigation.

Sources: Resident clinical records; investigation records; complaint records; PCC alert report; policy "Complaint and Customer Service" (reviewed April 2022); a CIS report; interviews with management and staff.

WRITTEN NOTIFICATION: Orientation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (1) 2.
Orientation
s. 259 (1) For the purposes of paragraph 11 of subsection 82 (2) of the Act, the following are additional areas in which training shall be provided:
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.

The licensee failed to ensure that staff were orientated with safe and correct use of equipment prior to performing their responsibilities as direct care staff.

Rationale and Summary
On a specified date, staff provided assistance with equipment to a resident, in which the resident alleged staff did not know how to use the device and that there was discomfort during care as a result.

Prior to starting to work at the long-term care home, agency staff members were not oriented and trained on the how to safely use and operate certain equipment. Staff confirmed that training was not provided by the home. Management acknowledged that there were no training attestation records for the topic on file for agency staff members.

There was a risk that agency staff were not familiar with the home's expectations for safe and correct use of therapeutic equipment when they did not receive orientation training as required.

Source: Staff training records; a resident's clinical record; investigation notes; interviews management and staff.

WRITTEN NOTIFICATION: Additional training- direct care staff

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 3.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management.

The licensee has failed to ensure that additional training for continence care and bowel management was provided to direct care staff.

Rationale and Summary
On a specified date, staff provided assistance with continence care for a resident.

Prior to starting to work at the long-term care home, agency staff were not oriented and trained on the home's continence care and bowel management expectations. Staff confirmed the training was not provided by the home. Management acknowledged that there were no training attestation records for the topic on file for agency staff members.

There was a risk that agency staff were not familiar with the home's expectations for continence care and bowel management when they did not receive orientation training as required.

Source: Staff training records; a resident's clinical record; investigation notes; interviews with management and staff.

WRITTEN NOTIFICATION: Resident Records

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary
A resident's family contacted staff on a specified date with concerns. Staff did not conduct an assessment of the resident on that date. Documentation related to the family's concern, action taken by the staff and remaining actions to be taken by the oncoming staff shift were not entered into the resident's clinical record until a later date. On a later date, the resident's family verbalized the same concern at a care conference and staff were unable to locate the related documentation or the nursing assessment. Further, the late entered documentation was absent from the shift report during the specified dates, which was reviewed by staff at oncoming shifts to triage resident concerns to be addressed.

Failure to ensure the resident's written record was kept up to date led to communication breakdown between staff and the resident's family, and may have contributed to delayed assessment of the resident's condition.

Sources: A resident's clinical record; a CIS report; and interview with staff.

WRITTEN NOTIFICATION: Staff Records

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 278 (1) 2.
Staff records
s. 278 (1) Subject to subsections (2) and (3), every licensee of a long-term care home

shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which they are a member, or verification of the staff member's current registration with the regulatory body governing their profession.

The licensee failed to ensure verification of a staff member's certificate of registration with the College of Nurses of Ontario (CNO) was kept.

Rationale and Summary
During the inspection, audit records were demonstrated indicating the licensee had not maintained verification of a staff member's certificate of registration with the CNO. The profile of the staff member was located on the CNO website "Find a Nurse" search feature and the staff was listed as entitled to practice with no restrictions.

Failure to keep a staff member's verification of registration with the applicable College demonstrated a gap in the home's staff record keeping processes.

Sources: CNO website; staff file audit records; interviews with management.

COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (12) 5.
Infection prevention and control program
s. 102 (12) The licensee shall ensure that the following immunization and screening measures are in place:
5. There must be a staff immunization program in accordance with any standard or

protocol issued by the Director under subsection (2). O. Reg. 246/22, s. 102 (12); O. Reg. 66/23, s. 23.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 102 (12) 5. [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
The licensee shall prepare, submit, and implement a plan to ensure that all nursing staff tuberculosis (TB) screening records are maintained as part of the employee's record, in accordance with the home's staff immunization program. For the purpose of this order, nursing staff includes personal support workers (PSWs) and registered nursing staff.

The plan must include but is not limited to:
1) Overview of the home's current employee file audit process related to TB screening results, specifically:
a. Who is responsible for completing auditing activities
b. Description of which staff files were audited
c. Initial follow-up actions taken with staff based on audit results

2) A process for tracking receipt of TB screening results for current staff who were identified as not having TB screening records on file and newly onboarding staff.

3) Description of follow-up actions to be taken if current staff do not provide TB screening results by a specified date.

4) Documentation of audits, receipt of TB screening records from nursing staff, and any follow-up actions taken with staff to be maintained for LTC Homes Inspector review.

Please submit the written plan for achieving compliance for inspection to

LTC Homes Inspector, MLTC, by email by a specified date. Please ensure that the submitted written plan does not contain any personal information/personal health information (PI/PHI).

Grounds
The licensee has failed to ensure that their staff immunization program was followed for multiple staff.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a staff immunization protocol and that it was complied with.

Specifically, the "Staff Immunizations and Tuberculosis (TB) Testing" policy, which was part of the staff immunization program, was not complied with.

Rationale and Summary
In an interview with management, audits completed by nursing management indicated a gap in TB screening records across nursing department staff members currently employed by the home.

The home's policy related to staff TB testing required all new staff to provide a copy of their TB test results completed in the past year. Staff without a TB test completed within the past year were to have a test completed as a condition of hire. The DOC or designate were to verify that each new employee submitted a completed form titled "Staff Immunization/TB Testing Record" and ensure a copy of this record was retained in the staff member's employment file.

There was a risk to resident health and safety when the licensee failed to maintain a record of TB screening completion for staff who provided direct care to residents.

Sources: Staff date of hire records; staff file audit records; policy "Staff Immunizations and Tuberculosis (TB) Testing" (reviewed January 2024); interviews

with management staff.

This order must be complied with by April 4, 2025

COMPLIANCE ORDER CO #002 Duty to protect

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee shall:

1) Re-educate identified staff on the home's policy related to the prevention of abuse and neglect, specifically on:

a) The definition of neglect and any aspects pertaining to ensuring residents are not neglected by the licensee or staff.

b) The definition of physical abuse, verbal abuse, and any aspects pertaining to ensuring residents are protected from abuse by anyone.

2) Document the education, including the components of education, the date the education was provided, the name of the staff receiving education, and the name of the staff member(s) who provided the education.

3) Perform audits of the identified staff for a specified period of time to ensure that the staff is providing care to a resident as required on a specified shift and that the identified staff is responding to the resident's requests for assistance in a timely manner.

4) Maintain a record of these audits for inspector review including the dates the audits were completed, the name of staff members who were audited, the name of the staff member(s) who completed the audits, and corrective actions (if any) that were taken after the completion of the audits.

Grounds
A) The licensee has failed to ensure that a resident was protected from neglect by staff.

Rationale and Summary
Section 7 of O. Reg 246/22 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was received by the Ministry of Long-Term Care regarding staff leaving a resident unattended during specified care tasks where staff assistance was required. A resident required assistance from staff with their activities of daily living. The resident was at risk of falls and staff were directed to respond promptly to all requests for assistance.

A review of camera footage on a specified date, showed a resident requesting staff assistance by activating their call bell at a specified time.

Camera footage showed a staff member near the home area's call bell modem when the resident rang the call bell. The staff member did not attend to the resident's call bell and departed from the home area without responding.

At a later time, multiple staff were observed by the call bell modem while the resident's call bell remained active. The staff members did not respond to the resident's call bell at that time. A staff member started replenishing supplies outside

other resident rooms and another staff member was observed sitting by the nursing desk when the resident's call bell remained active at a later time.

Staff did not respond to the resident's call bell in a timely manner.

Management stated it is the expectation from staff to respond to a resident's call bell as soon as possible and prioritize the call bell over non-essential tasks. Management also acknowledged that the resident's care needs were not addressed when staff neglected to respond to their call bell promptly and that the resident was at risk of harm related to potential unmet needs.

There was risk to the resident's safety when the staff members neglected the resident's care needs by not responding to the call bell in a timely manner.

Sources: A resident's plan of care; camera footage from incident; interviews with management.

B) The licensee failed to protect a resident from verbal abuse by staff.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines "verbal abuse" as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Rationale and Summary
On a specified date, a resident's POA made a complaint that a resident was verbally abused by a staff member.

The resident's clinical records confirmed that the verbal abuse affected the resident.

In an interview with management, it was confirmed that the verbal abuse by the staff member was founded, and the resident was affected by the verbal abuse.

Failure to protect a resident from verbal abuse by staff affected the resident emotionally.

Sources: A resident's clinical records; CIS report; interview with management; home's investigation notes; home's complaint log.

C) The licensee has failed to ensure that a resident was protected from verbal abuse by a staff member.

Rationale and Summary
O. Reg 246/22 s. 2 (1) (a) defines "verbal abuse" as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity, or self-worth, that is made by anyone other than a resident.

On a specified date, a staff member was observed yelling at and gesturing to a resident's face when the resident requested assistance with their care. Another staff member witnessed and reported the incident to the home's management.

The staff member stated they were overwhelmed on the date of the incident, which led to the verbal abuse. They also acknowledged that they should not have gestured and spoke to the resident with a raised voice tone. Management confirmed that the resident was verbally abused by the staff member. Management also indicated that the staff was exempted from providing care to the resident and that they received training on the home's prevention of resident abuse and neglect policy.

A resident was at risk of emotional harm when the licensee failed to protect them from verbal abuse by a staff member.

Sources: CIS report; interviews with staff and management.

D) The licensee failed to protect a resident from emotional and verbal abuse by another resident.

Under the O. Reg 246/22 s. 2, "emotional abuse" is defined as any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Under O. Reg. 246/22 s. 2, "verbal abuse" is defined as any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for their safety where the resident making the communication understands and appreciates its consequences.

Rationale and Summary
On a specified date, a resident was outside with a staff member nearby monitoring them. The resident began yelling and gesturing towards another resident outside. The staff member went between the resident's to prevent an altercation. The resident continued to yell at the other resident, calling them a derogatory term.

The resident was emotionally effected by what was said and stated they felt intimidated by the gesturing and remarks made by the other resident. As a result of the intimidating nature of the other resident's behaviour, an attempt at a physical altercation occurred.

Staff was able to separate the two residents and they were assessed by registered staff. The staff acknowledged that the two residents had a history of verbal

altercations, and that one of the resident's required staff observation due to behaviours. Management acknowledged that the resident understood and appreciated the impact of what was said.

There was a risk to the emotional wellbeing of a resident when the home failed to prevent emotional and verbal abuse by another resident.

Sources: Clinical record for two residents; CIS report; interviews with a resident, staff, and management.

E) The licensee failed to protect a resident from neglect by staff.

Rationale and Summary
Section 7 of the O. Reg 246/22 defined "neglect" as failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. Further, the home's policy to promote zero tolerance of resident abuse and neglect listed one of the indicators of neglect as undetected or untreated pressure injuries.

A concern was raised to staff on a specified date with concerns related to skin and wound management and pain management. The staff member did not complete an assessment of the resident's skin integrity or pain on that date. Reports from the oncoming staff and shift report documentation demonstrated that the staff member did not communicate the concerns to oncoming staff. Additionally, staff did not document the concerns in the resident's plan of care; therefore, it was absent.

The concerns were raised again at a care conference, staff identified that no follow-up had occurred with the resident or their family related to the concerns. Following the care conference, staff completed a skin assessment, identified altered skin integrity and noted the resident was experiencing pain. Management acknowledged

that the resident was neglected by staff when they did not complete the required care or communication tasks consistent with the resident's needs.

Failure to protect a resident from neglect by staff posed a risk of worsening skin integrity and may have led to an extended period of discomfort for the resident.

Sources: A resident's clinical record; policy "Zero Tolerance of Resident Abuse and Neglect Program" (reviewed November 2023); Appendix 1 "Possible Signs of Abuse or Neglect"; policy "Change of Shift Report" (reviewed March 2023); CIS report; LTCH investigation records; shift report documentation; interviews with management and staff.

This order must be complied with by February 28, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same

requirement.

Compliance History:
FLTCA 2021, s. 24 (1)

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #003 Staff Records

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 278 (1) 3.
Staff records
s. 278 (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
3. Where applicable, the results of the staff member's police record check under subsection 81 (2) of the Act.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 278 (1) 3. [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
The licensee shall prepare, submit and implement a plan to ensure that the results

of vulnerable sector checks (VSCs) under subsection 81 (2) of the Act are kept for nursing staff, including personal support workers and registered nursing staff.

The plan must include but is not limited to:
1) Overview of the home's current employee file audit process related to VSC results, specifically:
a) Who is responsible for completing auditing activities
b) Description of which staff files were audited
c) Initial follow-up actions taken with staff based on audit results

2) A process for tracking receipt of VSC results for current nursing staff who were identified as not having VSC results on file and newly onboarding staff.

3) Description of follow-up actions to be taken if current staff do not provide VSC results by a specified date.

4) Documentation of audits, receipt of VSC results from nursing staff, and any follow-up actions taken with staff to be maintained for LTC Homes Inspector review.

Please submit the written plan for achieving compliance for inspection the inspection to a LTC Homes Inspector, MLTC, by email by a specified date. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee failed to ensure the results of multiple staff police record checks under subsection 81 (2) of the Act were kept.

Rationale and Summary
A) During the inspection, it was found that a staff member was involved in a verbal abuse to a resident incident and the vulnerable sector check for the staff was not located in the staff's personnel file.

In an interview with management it was confirmed that they did not have a copy of the vulnerable sector check for the staff member on file. It was identified as missing, and the home had requested a copy from the staff.

Failure to comply with the Act and have a vulnerable sector check completed and on file potentially put residents at risk of harm.

Sources: CIS report; interview with management; home's investigation notes; staff personnel files.

Rationale and Summary
B) O. Reg 246/22 s. 252 (3) described that the police record check, as required under s. 81 (2) of the Act was to be a vulnerable sector check (VSC), be conducted to determine the person's suitability to be a staff member in a LTCH and to protect residents from abuse and neglect.

i) A CIS report was submitted to the MLTC alleging a staff member neglected the care needs of a resident. Management indicated the LTCH did not have a VSC on file for the staff member.

ii) During the interview with management, audits completed by nursing management indicated a gap in VSC records across nursing department staff members, including staff hired after O. Reg. 246/22 came into effect on a specified date.

There was a risk to resident safety when the licensee failed to keep VSC results for staff who provided direct care to residents.

Sources: Staff employment records; CIS report; staff date of hire records; staff file audit records; interviews with management.

This order must be complied with by April 4, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

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

Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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