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**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
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Bureau régional de services de Toronto
5700, rue Yonge 5e étage
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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 |
|---|---|---|---|
| Mar 10, 2020 | 2020_766500_0001 (A1) | 024097-19, 000047-20 | Complaint |

## Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Silverthorn Care Community
4350 Mississauga Road MISSISSAUGA ON L5M 7C8

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

Amended by NITAL SHETH (500) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**The report was amended for the non-compliance under s. 3 (1) 1 to correct resident #003 to resident #001.**

**Issued on this 10th day of March, 2020 (A1)**

**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*

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


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

Amended by NITAL SHETH (500) - (A1)

## 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): January 6, 7, 8, 9, 10, 13, 14, 15, 17, 20, February 3, 5, 6, 7, 10, 11, 2020.**

**The intake log #024097-19 and #000047-20 (CIS # 2956-000023-19 ) related to duty to protect were inspected in this inspection.**

**This report includes a non-compliance identified under s.6 (7) for residents #004, #005, #006 and #007, and under s. 19 (1) for resident #004 during inspection #2020_766500_0003, which was conducted concurrently.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Associate Director of Care (ADOC), the Human Resource Operations Coordinator, Scheduling Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Resident and the Family Members.**

**During the course of the inspection, the inspector observed the residents' care areas, and reviewed the residents' and home's records.**

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

**Dignity, Choice and Privacy**
**Infection Prevention and Control**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**

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

**5 WN(s)**
**3 VPC(s)**
**2 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to protect residents #001 and #004 from physical abuse by anyone.

For the purposes of the definition of “physical abuse” in subsection 2 (1) of the “physical abuse” means, (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident. O. Reg. 79/10, s. 5.

Ministry of Long-Term Care (MLTC) received a complaint about an alleged staff to resident abuse, and concerns related to the resident’s care.

A review of the Critical Incident System (CIS) report indicated that a complainant reported to the home about resident #001 being abused by two identified and two unidentified staff members in the home.

A review of video footage provided by the complainant indicated that the Personal Support Worker (PSW) brought resident #001 into their room by pushing their wheelchair. The PSW pulled an identified part of the resident's body, and the resident expressed pain by verbal and non-verbal expressions.

The PSW #103, after viewing the video footage, confirmed that their actions towards the resident was considered as abuse.

Interviews with PSWs #104, #106, #108, #109, #111, #112, Registered Nurse (RN) #105, #107 and #110 confirmed that PSW #103’s actions was considered as abuse.

Interviews with the Director of Care (DOC) and the Executive Director (ED) acknowledged that the PSW roughly handled the resident.

This non-compliance is issued as a result of physical abuse of the resident as evidence by their expressions related to pain, when the PSW applied physical force to the resident’s body part. [s. 19. (1)]

2. A review of a CIS report indicated an incident of staff to resident abuse. Agency Registered Practical Nurse (RPN) #115 witnessed PSW #114 roughly providing

specified care to resident #004. PSW #114 raised the tone of their voice and pushed the resident's body part away as the resident was trying to push the PSW's hand away. The resident reported having pain due to PSW #114 providing the above mentioned specified care.

A review of resident #004's incident form indicated that Agency RPN #115 heard yelling and screaming when they were coming out of the medication room. Agency RPN #115 found PSW #114 providing specified care to resident #004 in a rough manner and in an aggressive mood. Agency RPN #115 saw the resident was screaming, trying to hold PSW's hands and climbing out from the wheel chair. Agency RPN #115 asked the resident if they had pain related to the PSW providing specified care and the resident said "yes". Agency RPN #115 stopped the PSW.

A review of a pain assessment indicated that the resident was experiencing new moderate pain symptoms during specified care provided by the PSW.

The inspector was unable to interview PSW #114 who was no longer working with the home. The inspector called the agency and the agency reported that RPN #115 was no longer working with them.

A review of the home's investigation notes indicated that the home's video surveillance corresponds with RPN #115's statement and the PSW's actions towards the resident. The home's investigation notes determined physical abuse was substantiated from PSW #114 to resident #004.

A review of the home's policy #VII-G-10.00, entitled, "Prevention of Abuse & Neglect of a Resident", revised April 2019, indicated that all residents have the right to dignity, respect and freedom from abuse and neglect. The policy defined abuse as the physical force by anyone other than a resident, that causes pain or may cause pain.

Interview with the DOC acknowledged that the abuse was substantiated, and disciplinary actions imposed on the staff.

This non-compliance was issued as a result of staff to resident physical abuse causing harm to the resident. [s. 19. (1)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

MLTC received a complaint about an alleged staff to resident abuse, and concerns related to the resident's care.

A review of the CIS report indicated that the family reported to the home about resident #001 being abused by two identified and two unidentified staff members in the home.

A review of video footage provided by the complainant indicated PSW #109 and RN #110 transferred and repositioned resident #001 by using unsafe techniques.

Interviews with PSW #109 and RN #110 confirmed that they are required to use safe transferring and positioning techniques.

Interviews with the DOC and ED confirmed that staff should have used safe transferring and positioning techniques for the residents.

This non-compliance is issued as a result of staff having failed to use safe positioning techniques. [s. 36.]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

(A1)
1. The licensee has failed to ensure that the right of resident #001 to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, was fully respected and promoted.

MLTC received a complaint about an alleged staff to resident abuse, and concerns related to the resident's care.

A review of the CIS report indicated that a complainant reported to the home about resident #001 being abused by two identified and two un-identified staff members in the home.

A review of video footage provided by the complainant indicated that on separate occasions:
- PSW #103 used resident #001's personal washroom for their personal use

- PSW #103 made resident #001 scream during care and PSW #103 said "Stop" in a loud tone.

- PSW #103 roughly put resident #001 on the bed.

- PSW #108 offered resident #001 a food item inappropriately.

- PSW #106 made resident #001 walk with improper dressing.

- PSW #103 roughly made resident #001 sit in the wheelchair, roughly put the resident in bed and forced them to the pillow.

- PSW #103 pulled resident #001's head inappropriately while providing dressing care with the agency staff (identified by the DOC).

-PSW #103 pull the resident #001's head down by holding their neck. PSW #103 made the resident sit in their wheelchair forcefully and roughly.

- PSW #103 opened resident #001's Christmas Gift.

- PSW #112 forced resident #001 to sit in the wheelchair.

- PSW #106 and RN #105 assisted resident #001 with personal care. The resident slapped the staff. PSW #108 arrived and made an inappropriate comment to the resident. PSW #106 and #108 provided specified care for the resident while pushing the resident roughly against the wall in a standing position.

- During personal care, PSW #106 said "No" in a loud voice and pointed their finger to resident #001.

- PSW #106 made resident #001 walk while not being properly on three occasions.

- PSW #106 roughly adjusted the resident #001's clothing and made an inappropriate comment to the resident. PSW #106 transferred the resident to the

wheelchair. PSW #106 used the resident's body part roughly to position the resident in the wheelchair to move the resident towards the back rest.

Separate interviews with PSWs #103, #106, #108, #112, RNs #105, #107, #110, the DOC and the ED confirmed that staff are required to treat the residents with respect and dignity.

This non compliance is issued as a result of staff rough handling and having failed to treat resident #001 with respect and dignity. [s. 3. (1) 1.]

2. The licensee has failed to ensure that resident #002's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, was fully respected and promoted.

MLTC received a complaint about an alleged staff to resident abuse, and concerns related to the resident's care.

A review of a video footage provided by the complainant indicated that PSW #104 and #106 talked about resident #002's responsive behaviour in resident #001's room while providing care to resident #001.

Interview with PSW #104 confirmed that they were involved in a conversation about one resident's behaviour in front of another resident, and they should not do it to protect the resident's personal health information.

PSWs #104, #106, RN #107, the DOC and the ED confirmed that staff are expected to respect Residents' Bill of Rights.

This non-compliance is issued as a result of staff having failed to protect the resident's personal health information. [s. 3. (1) 11. iv.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted:***
***- every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity,***
***- every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #001, #004, #005, #006, and #007 as specified in the plan.

MLTC received a complaint about an alleged staff to resident abuse, and concerns related to the resident's care.

A review of the CIS indicated that a complainant reported to the home about resident #001 being abused by two identified and two unidentified staff members in the home.

a) A review of video footage provided by the complainant indicated the following:
- On an identified day, PSW #108 brought resident #001 into their room for toileting. PSW #108 left the resident in their wheelchair and did not provide any kind of care. PSW #108 spent time in the resident's room by fixing their own hair, using a mirror from the resident's drawer. PSW #108 spent some time in the resident's room and took the resident out of their room without providing any kind of care.

- On another identified day, PSW #108 brought the resident into their room for care. PSW #108 used the resident's mirror to fix their own hair and cleaned their own glasses. PSW #108 flushed the toilet and took the resident out of their room without toileting them.

A review of resident #001's written plan of care indicated that the resident required one to two staff to transfer the resident on and off the toilet, having a toileting schedule plan.

Interview with PSW #108 indicated that they were required to toilet resident #001 before and after meals during their shift. PSW #108 indicated that they would be required to transfer the resident onto the toilet at their scheduled toileting time, if the resident does not void, they would assist the resident off from the toilet.

Interviews with RNs #107, #110, and the DOC and ED confirmed that staff are required to toilet the resident as per their scheduled toileting routine.

b) A review of video footage indicated that on four identified days and five occasions, PSW #103, #112, #106 used a Personal Assistive Support Device (PASD) inappropriately.

A review of resident #001's written plan of care indicated that the resident required an identified device and to be used in a specified manner as consented by the SDM.

Interviews with PSWs #103, #106, #113, RNs #105, #107, and #110 confirmed that staff are expected to follow the resident's plan of care.

Interviews with the DOC and the ED confirmed that staff applied the resident's identified device inappropriately and acknowledged a need for further education.

c) Interview with resident #001's SDM indicated that the resident did not get enough sleep due to being disturbed by staff entering their room, and the resident became tired in the day time.

A review of a progress note indicated that the SDM requested staff not to disturb the resident during their sleep.

A review of a video footage indicated an identified staff opened the resident's door and closed it and after few minutes, came in and said, "Good Morning". The resident was sleeping.

A review of a video footage indicated a housekeeper went to the resident's room to change the garbage bags in the washroom and wiped the resident's door.

A review of a video footage indicated PSW #106 came to resident #001's room and said, "get up", "time to get up", and woke the resident up. After few minutes, RN #105 arrived at the resident's room and asked PSW #106 if the resident was awake, and PSW #106 replied "yes".

Interviews with RNs #105, and #107 indicated that the SDM communicated to the staff not to disturb the resident during their sleep. They confirmed that Housekeepers are not allowed to enter in the resident's room while they are sleeping. PSW #106, RNs #105, and #107 confirmed that they are expected to follow the resident's plan of care. [s. 6. (7)]

2. A review of CIS reports indicated that three medication error incidents occurred on an identified date. Residents #004, #005, and #006 did not receive their certain scheduled medications due to RPN #116 was behind in their medication administration pass.

A review of the residents' progress notes and medication administration records indicated that, residents #004, #005 and #006 did not receive their scheduled medications as per the order due to late administration.

Interview with the DOC confirmed that the staff are expected to follow the residents' plan of care and the above-mentioned residents should have received their evening medications dose as per the plan of care. [s. 6. (7)]

3. A review of a CIS report indicated that resident #007 had a fall incident with injury. The resident was transferred to the hospital.

A review of resident #007's written plan of care indicated that the resident was high risk for falls and required extensive assistance from two people for personal care.

Interview with PSW #109 indicated that on the time of the incident, they assisted

resident #007 by themselves without assistance from another staff member.

Interview with RPN #110 indicated that at the time of the incident, they received a call from PSW #109. PSW #109 reported resident #007's fall. RN #110 went to the resident's room and found the resident laying on the floor with an injury. They completed a quick assessment and called paramedics. RN #110 confirmed that PSW #109 reported to them that the resident asked them for assistance and PSW #109 transferred the resident to the toilet. RPN #110 confirmed that they documented the information provided by PSW #109. RPN #110 confirmed that staff are expected to follow the plan of care for the residents and resident #007 should have received two people assistance.

Interview with the DOC confirmed that the staff are expected to follow the residents' plan of care. Resident #007 should have received care from two people.

Interview with ED confirmed that staff are expected to implement the residents' plan of care.

This non-compliance was issued as a result of the staff having failed to provide care set out in the plan of care, when care wasn't provided to residents #001, #004, #005, #006, and #007 as specified in the plan. [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control (IPAC) program.

MLTC received a complaint about an alleged staff to resident #001 abuse, and concerns related to the resident's care.

A review of a video footage indicated that PSW #113 with gloves on, assisted resident #001 coming out of the washroom after toileting, with using a walker and transferred the resident to the wheelchair. PSW #113 was holding the resident's hand and touched the resident on the back of their shoulder. PSW #113 fixed the footrest on the resident's wheelchair, went to the washroom and brought the resident's comb and started fixing the resident's hair holding their head from the back. PSW #113 went back to the washroom to put away the comb and completed mouth care for the resident wearing the same gloves. The inspector did not see PSW #113 changing their gloves between tasks during care.

A review of a video footage indicated that PSW #112 provided care to resident #001 for toileting wearing gloves. PSW #001 transferred the resident to their wheelchair. Meanwhile, PSW #112 made the resident's bed and went to the washroom, flushed the toilet, and tied their own shoe laces with the same gloves on. Then PSW #112 picked up the resident's comb from the washroom, came to the resident, wiped the resident's face with the same gloves on, combed the resident's hair and continued with their tasks in the resident's room without changing their gloves, or performing hand hygiene.

Interviews with PSWs #112 and #113 indicated that they are required to change their gloves in between tasks, and before initiating a new task during residents' care to prevent infection in the home.

A review of the home's policy #IX-G-10.10, entitled, "Hand Hygiene", revised April 2016, indicated that all team members will practice hand hygiene before and after performing a procedure of task involving close resident contact, between tasks

and procedures on the same resident to prevent cross-contamination of different body sites, after contact with body substances or specimens, contaminated or soiled items (laundry, waste, equipment), and after using washroom/toilet.

A review of the home's policy #IX-G10.30, entitled, "Use of Gloves", revised January 2015, indicated that gloves must be changed, and hand hygiene is performed between care activities and procedures with the same resident after contact with materials that may contain high concentrations of microorganisms. Staff to change or remove gloves if moving from a contaminated body site to a clean body site within the same resident, after touching a contaminated environmental surface and before touching a resident or a clean environmental surface. Staff to remove gloves immediately and discard after the activity for which they were used, then perform hand hygiene.

Interview with the ADOC # 102 (Lead of the IPAC Program) confirmed that staff are required to change gloves and perform hand hygiene in between their tasks.

This non-compliance was issued as a result of staff having failed to participate in the IPAC program. [s. 229. (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 to ensure that all staff participate in the implementation of the Infection Prevention and Control (IPAC) program, to be implemented voluntarily.***

**Issued on this 10th day of March, 2020 (A1)**

[redacted]

**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 NITAL SHETH (500) - (A1) |
| **Inspection No. / No de l'inspection :** | 2020_766500_0001 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 024097-19, 000047-20 (A1) |
| **Type of Inspection / Genre d'inspection :** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Mar 10, 2020(A1) |
| **Licensee / Titulaire de permis :** | The Royale Development GP Corporation as general partner of The Royale Development LP<br>302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Silverthorn Care Community<br>4350 Mississauga Road, MISSISSAUGA, ON, L5M-7C8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Justine Welburn |

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 The Royale Development GP Corporation as general partner of The Royale Development LP, 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

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**Order # / No d'ordre:** 001

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee must be compliant with s. 19 (1) of the LTCHA, 2007. Specifically, the licensee must do the following:

1. Educate all staff on importance of the home's zero tolerance of abuse policy on various types of abuse and neglect. Conduct post-training evaluation to ensure comprehension of the education and maintain evaluation records.
2. Maintain record of requirement #1 including but not limited to who attended the education, who provided the education, the content of the education and the date the education was provided.

**Grounds / Motifs :**

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

1. The licensee has failed to protect residents #001 and #004 from physical abuse by anyone.

For the purposes of the definition of “physical abuse” in subsection 2 (1) of the “physical abuse” means, (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident. O. Reg. 79/10, s. 5.

Ministry of Long-Term Care (MLTC) received a complaint about an alleged staff to resident abuse, and concerns related to the resident’s care.

A review of the Critical Incident System (CIS) report indicated that a complainant reported to the home about resident #001 being abused by two identified and two unidentified staff members in the home.

A review of video footage provided by the complainant indicated that the Personal Support Worker (PSW) brought resident #001 into their room by pushing their wheelchair. The PSW pulled an identified part of the resident's body, and the resident expressed pain by verbal and non-verbal expressions.

The PSW #103, after viewing the video footage, confirmed that their actions towards the resident was considered as abuse.

Interviews with PSWs #104, #106, #108, #109, #111, #112, Registered Nurse (RN) #105, #107 and #110 confirmed that PSW #103’s actions was considered as abuse.

Interviews with the Director of Care (DOC) and the Executive Director (ED) acknowledged that the PSW roughly handled the resident.

This non-compliance is issued as a result of physical abuse of the resident as evidence by their expressions related to pain, when the PSW applied physical force to the resident’s body part. [s. 19. (1)]
(500)

2. A review of a CIS report indicated an incident of staff to resident abuse. Agency Registered Practical Nurse (RPN) #115 witnessed PSW #114 roughly providing specified care to resident #004. PSW #114 raised the tone of their voice and pushed the resident's body part away as the resident was trying to push the PSW's hand away. The resident reported having pain due to PSW #114 providing the above mentioned specified care.

A review of resident #004's incident form indicated that Agency RPN #115 heard yelling and screaming when they were coming out of the medication room. Agency RPN #115 found PSW #114 providing specified care to resident #004 in a rough manner and in an aggressive mood. Agency RPN #115 saw the resident was screaming, trying to hold PSW's hands and climbing out from the wheel chair. Agency RPN #115 asked the resident if they had pain related to the PSW providing specified care and the resident said "yes". Agency RPN #115 stopped the PSW.

A review of a pain assessment indicated that the resident was experiencing new moderate pain symptoms during specified care provided by the PSW.

The inspector was unable to interview PSW #114 who was no longer working with the home. The inspector called the agency and the agency reported that RPN #115 was no longer working with them.

A review of the home's investigation notes indicated that the home's video surveillance corresponds with RPN #115's statement and the PSW's actions towards the resident. The home's investigation notes determined physical abuse was substantiated from PSW #114 to resident #004.

A review of the home's policy #VII-G-10.00, entitled, "Prevention of Abuse & Neglect of a Resident", revised April 2019, indicated that all residents have the right to dignity, respect and freedom from abuse and neglect. The policy defined abuse as the physical force by anyone other than a resident, that causes pain or may cause pain.

Interview with the DOC acknowledged that the abuse was substantiated, and disciplinary actions imposed on the staff.

This non-compliance was issued as a result of staff to resident physical abuse causing harm to the resident. [s. 19. (1)] (500)

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**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Jun 15, 2020

## 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

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**Order # / No d'ordre:** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

**Order / Ordre :**

The licensee must be compliant with r. 36 of the LTCHA, 2007.
Specifically, the licensee must do the following:

1. Educate all direct care staff on safe transferring and positioning techniques using case study scenarios.
2. Conduct weekly audits for three months to ensure that staff are using safe transferring and positioning techniques for residents.
3. Maintain record of requirement #1 including but not limited to who attended the education, who provided the education and the date the education was provided and requirement #2 including but not limited to which staff and which resident was being audited, who completed the audit, the date of the audit and the outcome of the audit/actions taken as a result of the audit.

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

**Grounds / Motifs :**

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

MLTC received a complaint about an alleged staff to resident abuse, and concerns related to the resident's care.

A review of the CIS report indicated that the family reported to the home about resident #001 being abused by two identified and two unidentified staff members in the home.

A review of video footage provided by the complainant indicated PSW #109 and RN #110 transferred and repositioned resident #001 by using unsafe techniques.

Interviews with PSW #109 and RN #110 confirmed that they are required to use safe transferring and positioning techniques.

Interviews with the DOC and ED confirmed that staff should have used safe transferring and positioning techniques for the residents.

This non-compliance is issued as a result of staff having failed to use safe positioning techniques. [s. 36.]

The severity of this issue is a level 3 (actual risk), the scope was a level 1 (isolated), as it related to one out of three residents reviewed and compliance history was level 3 (previous non-compliance to the same subsection) that included Compliance Order (CO) and Written Notification (WN) issued during Inspection # 2017_570528_0022, dated June 29, 2017. (500)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 15, 2020

## 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:

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

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.

## 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

## 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 10th day of March, 2020 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Amended by NITAL SHETH (500) - (A1)

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

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**Service Area Office / Bureau régional de services :** Toronto Service Area Office