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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 11, 2020	2020_797740_0019	014761-20	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Aspen Lake
9855 McHugh Street WINDSOR ON N8P 0A6

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

SAMANTHA PERRY (740)

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): August 17, 18 and 19, 2020.

The following intake was completed within the Complaint inspection: Log# 014761-20 / IL-80471-LO related to allegations of financial abuse.

During the course of the inspection, the inspector(s) spoke with the General Manager, the billing specialist and the Vice President of Operations.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

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

1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, appropriate action taken, any requirements provided for in the regulations complied with and that the results of the investigation were reported to the Director.

Ontario Regulation 79/10 defines financial abuse as “any misappropriation or misuse of a resident’s money or property; (“exploitation financière”).

The Ministry of Long-Term Care (MLTC) received a complaint through the Ministry’s ActionLine, stating several concerns involving a resident at the home.

During the course of this inspection an email sent by the same complainant, received by General Manager (GM) #100, was reviewed and stated in part, the same concerns involving the same resident.

Review of the MLTC Critical Incident reporting system showed that the home did not contact the Service Ontario After-Hours Line, nor did the home submit a Critical Incident System (CIS) report or submit a response to the MLTC related to the complaint email received.

Review of the Schlegel Villages policy titled manual: “Human resources, Section: Code of Conduct, Subject: Prevention of Abuse and Neglect”, policy #04-06, last updated on November 14, 2019 stated the following:
- Under the heading: “Policy: Schlegel Villages has a zero tolerance with respect to abuse of any kind, including physical, sexual, emotional, verbal, financial and neglect, from any person (team members, residents, families, visitors, volunteers, students, contracted staff, agency staff, or companions). The zero tolerance for resident abuse and neglect will be enforced and reported as per the mandatory reporting obligations of the Long-Term Care Act, 2007 s. 19, s. 20”.

Additionally, further review of the same policy stated the following:
- Under the heading: “INVESTIGATION AND REPORTING ALLEGED / SUSPECTED ABUSE: To outline the standard process to be used during witness of abuse/neglect and/or on receiving a report of an allegation or suspicion; the reporting process includes: Immediate response for the safety for all persons; Immediate care to the resident(s) that is individual, respectful, culturally sensitive, and ethical, in a therapeutic environment; Immediate internal and MOH incident reporting/documentation; Follow-up action plans and analysis which foster resident, visitor and team member safety after each occurred incident. [O. Reg. 79/10, s. 96]
- Under the heading: “INVESTIGATION PROCESS: Please refer to the following policies: Tab 04-06A, Investigation Process for Suspected Resident to Resident Abuse; and Tab 04-06B, Investigation Process for Suspected Abuse of a Resident by Team Member, Volunteer or Visitor.”

When asked, the home was unable to provide any written records of their response and/or communication with the complainant, investigation/follow-up action plan and analysis, or a Critical Incident System (CIS) report related to the complaint email received by the home.

GM #100 stated they were familiar with the resident and the complainant. When asked for the home’s written response to the complaint email, as required for the Complaint/Response legislative requirements, GM #100 stated they were not sure and

would look into it. Furthermore, when asked if a corresponding Critical Incident System (CIS) report was submitted to the Director, GM #100 said no.

When asked if there was a documented investigation/follow-up action plan and analysis completed by the home when the home became aware of the concerns, as stipulated in the home's "Prevention of Abuse and Neglect" policy, under the heading: "INVESTIGATION AND REPORTING ALLEGED / SUSPECTED ABUSE", GM #100 said no. GM #100 said the home did not think they had reasonable grounds to pursue an investigation or report to the Director. GM #100 was asked again if they had a written response to the complaint received. GM #100 provided a written response sent to the complainant through email; however, the response had not been submitted to the MLTC and did not address the complainant's concerns in their entirety.

The licensee failed to ensure that when they became aware of an allegation of abuse, that the allegation was immediately investigated, the appropriate action was taken, the requirements provided for in the regulations for investigating and responding were complied with and that the results of the investigation were reported to the Director. [s. 23. (1) (a)]

Additional Required Actions:

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

Issued on this 11th day of September, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMANTHA PERRY (740)
Inspection No. / No de l'inspection :	2020_797740_0019
Log No. / No de registre :	014761-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 11, 2020
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Aspen Lake 9855 McHugh Street, WINDSOR, ON, N8P-0A6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dana Houle

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Specifically, the licensee must comply with s. 23 (1):

A) The licensee will educate the management team, including but not limited to: the General Manager, the Director of Care, the Associate Directors of Care and any other pertinent management team member, on the process for reporting and investigating allegations of financial abuse.

B) The licensee will maintain a written record of:
- the education materials/content;
- the name of the employee(s) delivering the education materials;
- the date the education was received by each member of the management team;
- the names and signatures of each management team member to receive the education.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is

reported to the licensee, is immediately investigated, appropriate action taken, any requirements provided for in the regulations complied with and that the results of the investigation were reported to the Director.

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Immediate internal and MOH incident reporting/documentation; Follow-up action plans and analysis which foster resident, visitor and team member safety after each occurred incident. [O. Reg. 79/10, s. 96]
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The licensee failed to ensure that when they became aware of an allegation of abuse, that the allegation was immediately investigated, the appropriate action was taken, the requirements provided for in the regulations for investigating and responding were complied with and that the results of the investigation were reported to the Director. [s. 23. (1) (a)]

During this inspection, this non-compliance was found to have a severity of

actual risk to the resident(s). The scope was isolated as it had the potential to impact a minimal number of residents. The home had no previous history of non-compliance in this area. (740)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 29, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 11th day of September, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Samantha Perry

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