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
Aug 16, 2021	2021_605213_0018	005343-21, 006059-21, 006480-21, 008706-21, 008840-21, 009721-21, 009947-21, 010769-21, 010912-21	Critical Incident System

Licensee/Titulaire de permis

Henley Place Limited
200 Ronson Drive Suite 305 Toronto ON M9W 5Z9

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

Henley Place
1961 Cedarhollow Boulevard London ON N5X 0K2

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

RHONDA KUKOLY (213), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 2021.

The following intakes were completed as part of this critical incident inspection:
Log #005343-21, Critical Incident #3045-000022-21 related to resident to resident abuse.
Log #006059-21, Critical Incident #3045-000025-21 related to resident to a fall.
Log #006480-21, Critical Incident #3045-000028-21 related to resident to a fall.
Log #008706-21, Critical Incident #3045-000034-21 related to resident to resident abuse.
Log #008840-21, Critical Incident #3045-000035-21 related to resident to a fall.
Log #009721-21, Critical Incident #3045-000037-21 related to resident to resident abuse.
Log #009947-21, Critical Incident #3045-000038-21 related to resident to staff to resident abuse.
Log #010769-21, a complaint related to care.
Log #010912-21, Critical Incident #3045-000042-21 related a fracture.

During the course of the inspection, the inspector(s) spoke with the Vice President of Primacare Living Solutions, the Acting Administrator, the Acting Director of Care, the Assistant Director of Care, the Corporate Program Manager, the Life Enrichment Manager, the Acting Environmental Services Manager, the Environmental Services Manager, a Nurse Practitioner, a Physiotherapist, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Resident Support Attendant, a Restorative Care Aide, a Housekeeper, a Maintenance Staff Member and residents.

Inspectors also made observations and reviewed health records, policies and procedures, evaluations, investigation records, education records, and other relevant documentation.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **7 WN(s)**
- **2 VPC(s)**
- **9 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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care for three residents was based on an assessment of the resident and the needs and preferences of that resident related to the use of footrests for mobility in wheelchairs.

Several residents were observed being pushed in wheelchairs without the use of footrests and were not assessed related to their need for footrests. Staff had no direction related to the use of footrests for residents, which put residents at risk for injury. The Acting Director of Care (DOC) said that residents who required wheelchairs should have been assessed for the use of footrests and direction for staff related to the use of footrests should have been included in the plans of care.

Sources: An anonymous complaint to the MLTC, residents' health records, observations and staff interviews. [s. 6. (2)]

2. The licensee has failed to ensure that Resident Support Attendants, who provided direct care to residents, were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

A Resident Support Attendant (RSA) said that RSAs did not have access to care plans,

kardexes, or to Point Click Care. RSAs assisted with transfers, portering residents, and assisted residents with feeding during meals and snack cart. The RSA said that the only way they knew what to do for a resident was watching what Personal Support Workers did and asking them what to do.

The Acting Administrator said the home had been using RSAs for resident care since the start of the pandemic over a year ago, that RSAs did not have access to Point Click Care and did not document the care they provided. They acknowledged that there was risk to resident safety over the past year, when RSAs did not have access to residents' plans of care when providing care for residents.

Sources: Staff interviews. [s. 6. (8)]

3. The licensee has failed to ensure that a resident was reassessed and the plan of care revised when their transferring needs changed.

A resident had a fall and suffered a significant change in condition; their care plan was revised for transfers and toileting. Staff said the resident's condition had improved since then but the resident's transfer had not been reassessed and the care plan was not further revised to reflect the change in assistance required for transfers and toileting.

Sources: Critical Incident report, health records, observations and staff interviews. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are reassessed and the plan of care revised when needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Findings/Faits saillants :

1. The licensee has failed to ensure that air temperatures were measured three times per day in at least two resident bedrooms in different parts of the home, in one resident common area on every floor of the home, which may include a lounge, dining area or corridor.

There were no records for any air temperatures in the afternoon, evening or night. The Primacare Living Solutions Heat Related Illness policy was revised in May 2021 and matched the current legislation related to measuring air temperatures. Maintenance staff said that they measured air temperatures in common areas once daily in the morning. The Acting Director of Care and the Acting Administrator said that air temperatures were not measured anywhere in the home in the afternoon, evening, they were only taken in common areas in the morning by maintenance staff.

There was a risk to residents related to heat related illness, when air temperatures were not measured or monitored three times per day in the home during the summer months.

Sources: The Primacare Living Solutions Heat Related Illness policy and staff interviews. [s. 21.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept for the 2020 Infection Prevention and Control (IPAC) Program Evaluation.

The IPAC program evaluation form was dated as completed December 1, 2020. There was no written record that included a summary of the changes made and the date that those changes were implemented. Target dates were indicated for 2020 instead of for the new year 2021.

The Resident Vaccination tuberculosis (TB) Testing Consent policy had a revision date of November 2013, and was not compliant with current public health recommendations for TB screening for residents over 65 years of age, through chest x-ray, not Mantoux test.

With policies not reviewed and revised, the program did not meet public health recommendations and with valid target dates not documented, there was ongoing risk of improvements not being implemented.

Sources: The Resident Vaccination TB Testing Consent policy #02-04 with a revision date of November 2013, the 2020 IPAC program evaluation, interview with the Vice President of Primacare Living Solutions.[s. 229. (2) (e)]

2. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program when resident hand hygiene was not being performed and no hand hygiene audits were being completed.

O. Reg 79/10 s. 229 (9) states: The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

No resident hand hygiene was observed throughout the inspection, on different floors, at different times, on different dates. The Acting Director of Care (DOC) and the Vice President (VP) of Primacare Living Solutions stated the expectation was that staff encourage and assist residents as needed, with performing hand hygiene with either alcohol based hand rub or soap and water, before and after meals.

The Infection Control Program policy stated, the Infection Control Program within the home will include a comprehensive hand hygiene program, hand hygiene audit and annual education for staff. The last hygiene audit completed in 2021, was January 26, 2021. The Vice President of Primacare Living Solutions stated the expectation was that hand hygiene audits were completed for resident and staff hand hygiene, as per the Infection Control Program.

There was risk of spread of infection when resident hand hygiene was not completed and when hand hygiene audits were not being completed, to ensure hand hygiene was being completed in the home.

Sources: Hand Hygiene policy, the Infection Control Program, hand hygiene audits, observations, 2021 and staff interviews. [s. 229. (4)]

3. The licensee has failed to ensure that residents were screened for tuberculosis (TB) within 14 days of admission and that residents were offered immunization against influenza, pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules.

The Resident Vaccination tuberculosis (TB) Testing Consent policy had a revision date of November 2013, and was not compliant with current public health recommendations for TB screening for residents over 65 years of age, through chest x-ray, not Mantoux test.

Heath records for a resident showed no record of a chest x-ray or TB screening and no record of vaccination against influenza, tetanus or diphtheria. There was no record of dates of vaccination dates for Covid-19. Registered staff said that they had not had any vaccines in the home for several months and likely any resident admitted in 2021 had not had any vaccines administered.

The Acting Director of Care (DOC) was not aware that vaccines were not available in the home and residents were not being screened for TB, or offered vaccination as per the publicly funded immunization schedules.

There was risk of resident illness and spread of infection when TB screening was not completed and residents were not offered pneumovax, influenza, tetanus and diphtheria vaccinations and there was no record of dates of Covid-19 vaccination.

Sources: Resident Vaccination TB Testing Consent policy, resident health records, staff interviews. [s. 229. (10)]

Additional Required Actions:

CO # - 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written description of the program that included relevant policies, procedures and protocols for the Falls Prevention and Management Program.

The policy in place to direct clinical practice did not provide the current relevant procedure related to the neurological monitoring and documentation of a head injury. Timed neurological checks were inconsistent across the Point Click Care assessment, the neurological record and the policy in place. There was potential risk to residents who required specific timed monitoring of neurological signs of a head injury.

Sources: Primacare Neurological Signs/Head Injury Routine Policy Number 08-45 with current version date July 2010, Primacare Neurological Signs/Head Injury Vital Signs Records Resident Care 08-45a, PLS Neurological Checks - V 3, and staff interviews. [s. 30. (1) 1.]

2. The licensee failed to ensure there was a written record related to the Falls Prevention and Management Program and the Pain Management Program evaluations with the names of the persons who participated, a summary of the changes made and the date that those changes were implemented.

The evaluation of the two required programs were incomplete and although the identified needs for change and improvement were documented for the new year, there was no documented implementation of the improvements or recommendations. The participants in the evaluation did not evaluate the falls prevention or pain program. The home had no documented record of the changes, when they were implemented, the outcome of the change or who was responsible. Quality indicators, assessments, monitoring, interventions, and policies were not evaluated by the participants listed. With valid target dates not documented, there was potential risk that the program would not improve in the area of the identified need.

Sources: Annual Program and Developmental Evaluation for the Falls Prevention and Management (Reg 49) Program, Annual Program and Developmental Evaluation for the Pain Management (Reg 52) Program, and staff interviews. [s. 30. (1) 4.]

3. The licensee failed to ensure that any actions taken with respect to a resident under the Falls Prevention and Management program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

Two Critical Incident System (CIS) reports were submitted to the Ministry of Long Term Care regarding resident to resident physical altercations. Head Injury Routines were not completed in full when it was clinically appropriate. On further review, on one home care area, over a seven month time frame, there were 14/38 or 36.8% of residents with incomplete assessment findings at specific intervals during the head injury routine that was monitored for 72 hours.

There was potential risk to residents when registered nursing staff did not assess and determine the subtle changes in level of consciousness, vital signs, pupil reactions, and

motor response.

Sources: PLS Neurological Checks - V 3 assessments, resident clinical records and staff interviews. [s. 30. (2)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 there is a written record related to the Falls Prevention and Management Program and the Pain Management Program with the names of the persons who participate in the evaluation and a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect the improper or incompetent treatment or care of a resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

An anonymous complaint was received by the Ministry of Long-Term Care regarding a resident who suffered an injury when a staff member was pushing them in a wheelchair without footrests on the wheelchair. The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care eleven days after the incident, as Improper/Incompetent treatment of a resident that resulted in harm or risk of harm to a resident.

Progress notes and staff interviews confirmed that an incident occurred that resulted in an injury to a resident with a significant change in condition. When the incident was not acknowledged as a critical incident and reported, it was then not investigated and appropriate actions were not taken, which left residents in ongoing risk for injury.

Sources: A complaint to the MLTC, a critical incident report, resident health records and staff interviews. [s. 24. (1) 1.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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 ensure that a resident was not neglected.

An anonymous complaint was received by the Ministry of Long-Term Care regarding a resident who suffered an injury when a staff member was pushing them in a wheelchair without footrests on. The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care eleven days after the incident, as Improper/Incompetent treatment of a resident that resulted in harm or risk of harm to a resident. The investigation related to the incident was not initiated until fourteen days after the incident, after inspectors questioned it.

Progress notes for the resident indicated that an incident occurred when the resident's foot went down when being pushed in their wheelchair by staff, causing the resident extreme pain. This note was not documented until nine days after the actual incident. Staff working on the day of and the days after the incident said the resident reported extreme pain affecting their activities of daily living and that the incident and the pain were reported to registered staff.

There was no shift report for oncoming staff regarding the incident or injury, no documentation in the resident's progress notes and no communication related to the incident or injury for over 24 hours. No pain assessments were completed the day of or the day after the incident. The resident's electronic Medication Administration Records showed pain levels documented as zero on the day of and the day after the incident. No PRN pain medication was administered to the resident on the day of the incident.

The Acting Director of Care (DOC) said that they were informed of the injury the day after it occurred, and that they were not informed of the incident the day prior. Fourteen days later, the Acting DOC said that no investigation of the incident had started as of that date, progress notes had not been reviewed and no staff had been interviewed to determine the cause of the injury or any gaps in care for the resident. The Acting DOC and the Vice President (VP) of Primacare Living Solutions agreed that the lack of assessment, lack of pain management, lack of investigation, lack of action, lack of documentation and lack of communication was neglect of the resident.

Sources: A complaint to the MLTC, a critical incident report, resident health records, observations and staff interviews. [s. 19. (1)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the incident of improper or incompetent treatment or care of a resident, that the licensee was aware of, was immediately investigated and appropriate actions were taken.

An anonymous complaint was received by the Ministry of Long-Term Care regarding a resident who suffered an injury when a staff member was pushing them in a wheelchair without footrests on the wheelchair. The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care eleven days after the incident, as Improper/Incompetent treatment of a resident that resulted in harm or risk of harm to a resident.

The Acting Director of Care (DOC) said that they were informed of the injury the day after it occurred, and that they were not informed of the incident the day prior. Fourteen days later, the Acting DOC said that no investigation of the incident had started as of that date, progress notes had not been reviewed and no staff had been interviewed to determine the cause of the injury or any gaps in care for the resident. Twenty-one days after the incident, the Acting DOC said that there had been no investigation completed related to the use of footrests for that or any other resident in the home.

When the incident was not acknowledged as a critical incident and reported, it was then not investigated and appropriate actions were not taken, which left residents in ongoing risk for injury.

Sources: A complaint to the MLTC, a critical incident report, resident health records and staff interviews. [s. 23. (1)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of 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

Issued on this 16th day of August, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	RHONDA KUKOLY (213), MELANIE NORTHEY (563)
Inspection No. / No de l’inspection :	2021_605213_0018
Log No. / No de registre :	005343-21, 006059-21, 006480-21, 008706-21, 008840-21, 009721-21, 009947-21, 010769-21, 010912-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 16, 2021
Licensee / Titulaire de permis :	Henley Place Limited 200 Ronson Drive, Suite 305, Toronto, ON, M9W-5Z9
LTC Home / Foyer de SLD :	Henley Place 1961 Cedarhollow Boulevard, London, ON, N5X-0K2
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Adam Banks

To Henley Place Limited, 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. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee must be compliant with s. 6 (2) of the LTCHA.
Specifically, the licensee must:
a) Develop and implement a protocol for assessing residents' need for the use of footrests.
b) Provide training to all staff who have a role in portering residents, regarding the use of footrests and safety in portering.
c) Provide training to all registered nursing staff, physiotherapy staff and any other staff involved in mobility assessments, regarding the protocol for assessing residents' need for the use of footrests.
d) Keep a written record of training content, staff and dates completed, to ensure that all staff complete the training.
e) Assess all residents who use wheelchairs for mobility, for the need for the use of footrests, document the assessments and ensure their plans of care include clear direction related to the use of footrests.

Grounds / Motifs :

1. The licensee has failed to ensure that care set out in the plan of care for three residents was based on an assessment of the resident and the needs and preferences of that resident related to the use of footrests for mobility in wheelchairs.

Several residents were observed being pushed in wheelchairs without the use of footrests and were not assessed related to their need for footrests. Staff had no direction related to the use of footrests for residents, which put residents at risk for injury. The Acting Director of Care (DOC) said that residents who required wheelchairs should have been assessed for the use of footrests and direction for staff related to the use of footrests should have been included in the plans of care.

Sources: An anonymous complaint to the MLTC, residents' health records, observations and staff interviews.

An order was made by taking the following factors into account:
Severity: There was actual harm to a resident. There was a significant change in condition to the resident.
Scope: The scope of this non-compliance was widespread with three out of three residents inspected that were not using footrests had not had an assessment completed or anything in the care plan regarding the use of footrests.
Compliance History: There was no non-compliance issued to the home related to s. 23 of the legislation in the past 36 months. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 26, 2021

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 : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Order / Ordre :

The licensee must be compliant with s. 6 (8) of the LTCHA.
Specifically, the licensee must:
a) Develop and implement a process to ensure that all Resident Support Attendants have access to all residents' plans of care.
b) Provide training to Resident Support Attendants regarding accessing, reading and implementing plans of care, and documentation.
c) Keep a written record of training content, staff and dates completed to ensure that all staff completed the training.

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 ensure that Resident Support Attendants, who provided direct care to residents, were kept aware of the contents of the resident’s plan of care and had convenient and immediate access to it.

A Resident Support Attendant (RSA) said that RSAs did not have access to care plans, kardexes, or to Point Click Care. RSAs assisted with transfers, portering residents, and assisted residents with feeding during meals and snack cart. The RSA said that the only way they knew what to do for a resident was watching what Personal Support Workers did and asking them what to do.

The Acting Administrator said the home had been using RSAs for resident care since the start of the pandemic over a year ago, that RSAs did not have access to Point Click Care and did not document the care they provided. They acknowledged that there was risk to resident safety over the past year, when RSAs did not have access to residents’ plans of care when providing care for residents.

Sources: Staff interviews.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm.
Scope: The scope of this non-compliance was widespread as no RSAs on any of the six resident care areas had access to care plans, therefore affecting all residents in the home.
Compliance History: There was no non-compliance issued to the home related to s. 23 of the legislation in the past 36 months. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 15, 2021

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 21. Air temperature

Order / Ordre :

The licensee must be compliant with s. 21 of O. Reg. 79/10.
Specifically, the licensee must:
a) Create and implement a protocol for the measurement and documentation of air temperatures as per O. Reg. 79/10 s. 21.
b) Complete weekly audits of documented air temperatures and follow up to ensure completion as required and appropriate follow up completed. Weekly audits to be completed until September 30, 2021.

Grounds / Motifs :

1. The licensee has failed to ensure that air temperatures were measured three times per day in at least two resident bedrooms in different parts of the home, in one resident common area on every floor of the home, which may include a lounge, dining area or corridor.

There were no records for any air temperatures in the afternoon, evening or night. The Primacare Living Solutions Heat Related Illness policy was revised in May 2021 and matched the current legislation related to measuring air temperatures. Maintenance staff said that they measured air temperatures in common areas once daily in the morning. The Acting Director of Care and the Acting Administrator said that air temperatures were not measured anywhere in the home in the afternoon, evening, they were only taken in common areas in the morning by maintenance staff.

There was a risk to residents related to heat related illness, when air temperatures were not measured or monitored three times per day in the home during the summer months.

Sources: Staff interviews.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm.
Scope: The scope of this non-compliance was widespread as none of the six resident care areas had temperatures monitored in all required areas since the legislation came into force.
Compliance History: There was no non-compliance issued to the home related to s. 23 of the legislation in the past 36 months. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2021

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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s. 229 (10).

Order / Ordre :

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

The licensee must be compliant with s. 229 (10) of O. Reg. 79/10.
Specifically, the licensee must:
a) Ensure that all residents previously admitted have been screened for tuberculosis (TB) and receive all required immunizations as per the publicly funded immunization schedule.
b) Ensure that all newly admitted residents are screened for TB and receive all required immunizations on admission as per the publicly funded immunization schedule.
c) Provide training for all registered nursing staff regarding TB screening and immunizations required for residents on admission.
d) Keep a written record of training content, staff and dates completed to ensure that all staff completed the training.
e) Complete monthly audits of new admissions for completion of TB screening and administration of required immunizations.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were screened for tuberculosis (TB) within 14 days of admission and that residents were offered immunization against influenza, pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules.

The Resident Vaccination tuberculosis (TB) Testing Consent policy had a revision date of November 2013, and was not compliant with current public health recommendations for TB screening for residents over 65 years of age, through chest x-ray, not Mantoux test.

Heath records for a resident showed no record of a chest x-ray or TB screening and no record of vaccination against influenza, tetanus or diphtheria. There was no record of dates of vaccination dates for Covid-19. Registered staff said that they had not had any vaccines in the home for several months and likely any resident admitted in 2021 had not had any vaccines administered.

The Acting Director of Care (DOC) was not aware that vaccines were not available in the home and residents were not being screened for TB, or offered vaccination as per the publicly funded immunization schedules.

There was risk of resident illness and spread of infection when TB screening was not completed and residents were not offered pneumovax, influenza, tetanus and diphtheria vaccinations and there was no record of dates of Covid-19 vaccination.

Sources: Resident Vaccination TB Testing Consent policy, resident health records, staff interviews.

An order was made by taking the following factors into account:
Severity: There was actual risk of harm.
Scope: The scope of this non-compliance was isolated with one out of three residents inspected did not have tuberculosis screening or immunizations.
Compliance History: There was no non-compliance issued to the home related to s. 23 of the legislation in the past 36 months. (213)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 26, 2021

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 : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.
Specifically, the licensee must:
a) Provide training for all staff involved in direct resident care including nursing, recreation and therapy staff, regarding resident hand hygiene.
b) Develop and implement a process for hand hygiene audit completion including frequency, timing, who is responsible, documentation required, review of audits and follow up.
c) Provide training for all staff deemed responsible for completing hand hygiene audits regarding the new process and responsibilities.
d) Keep a written record of training content, staff and dates completed to ensure that all staff completed the training.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program when resident hand hygiene was not being performed and no hand hygiene audits were being completed.

O. Reg 79/10 s. 229 (9) states: The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

No resident hand hygiene was observed throughout the inspection, on different floors, at different times, on different dates. The Acting Director of Care (DOC) and the Vice President (VP) of Primacare Living Solutions stated the expectation was that staff encourage and assist residents as needed, with performing hand hygiene with either alcohol based hand rub or soap and water, before and after

meals.

The Infection Control Program policy stated, the Infection Control Program within the home will include a comprehensive hand hygiene program, hand hygiene audit and annual education for staff. The last hygiene audit completed in 2021, was January 26, 2021. The Vice President of Primacare Living Solutions stated the expectation was that hand hygiene audits were completed for resident and staff hand hygiene, as per the Infection Control Program.

There was risk of spread of infection when resident hand hygiene was not completed and when hand hygiene audits were not being completed, to ensure hand hygiene was being completed in the home.

Sources: Hand Hygiene policy, the Infection Control Program, hand hygiene audits, observations, 2021 and staff interviews.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm.
Scope: The scope of this non-compliance was widespread as no residents on any of the six resident care areas were observed being assisted or encouraged with hand hygiene on any of the 11 days of the inspection.
Compliance History: There was no non-compliance issued to the home related to s. 23 of the legislation in the past 36 months. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 26, 2021

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 : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Order / Ordre :

The licensee must be compliant with s. 30 (2) of O. Reg. 79/10.

Specifically, the licensee must:
a) Ensure that the assessment used in the home to monitor and document assessment findings for head injury routine (HIR) is the prevailing practice identified as part of the home's neurological head injury routine policy.
b) Ensure that any resident who requires monitoring for neurological signs related to a head injury is assessed at the time intervals identified as part of the head injury assessment.
c) Ensure there is a process in place to communicate from shift to shift all residents who require active head injury routine monitoring and assessment.
d) Ensure staff communicate from shift to shift all residents who require active head injury routine monitoring and assessment.
e) Create and implement a tracking process to ensure the monitoring and assessment of neurological signs related to a head injury are completed as directed for any resident who requires head injury routine.

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 failed to ensure that any actions taken with respect to a resident under the Falls Prevention and Management program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

Two Critical Incident System (CIS) reports were submitted to the Ministry of Long Term Care regarding resident to resident physical altercations. Head Injury Routines were not completed in full when it was clinically appropriate. On further review, on one home care area, over a seven month time frame, there were 14/38 or 36.8% of residents with incomplete assessment findings at specific intervals during the head injury routine that was monitored for 72 hours.

There was potential risk to residents when registered nursing staff did not assess and determine the subtle changes in level of consciousness, vital signs, pupil reactions, and motor response.

Sources: PLS Neurological Checks - V 3 assessments, resident clinical records and staff interviews.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm to two residents. The home did not consistently assess the neurological signs of a head injury as specified.
Scope: The scope of this non-compliance was a pattern with 36.8 per cent of head injury routine assessments incomplete.
Compliance History: There was no non-compliance issued to the home related to s. 30 (2) of the legislation in the past 36 months. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 15, 2021

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 : 007

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the LTCHA.
Specifically, the licensee must:
a) Provide training to all staff related to mandatory reporting.
b) Keep a written record of training content, staff and dates completed to ensure that all staff completed the training.

Grounds / Motifs :

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect the improper or incompetent treatment or care of a resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

An anonymous complaint was received by the Ministry of Long-Term Care regarding a resident who suffered an injury when a staff member was pushing them in a wheelchair without footrests on the wheelchair. The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care eleven days after the incident, as Improper/Incompetent treatment of a resident that resulted in harm or risk of harm to a resident.

Progress notes and staff interviews confirmed that an incident occurred that resulted in an injury to a resident with a significant change in condition. When the incident was not acknowledged as a critical incident and reported, it was then not investigated and appropriate actions were not taken, which left residents in ongoing risk for injury.

Sources: A complaint to the MLTC, a critical incident report, resident health records and staff interviews.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm.
Scope: The scope of this non-compliance was isolated with only one incident of improper/incompetent treatment.
Compliance History: One Written Notification (WN) was issued to the home related to s. 24 (1) of the legislation in the past 36 months. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 26, 2021

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 : 008

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.
Specifically, the licensee must:
a) Develop and implement a protocol for shift to shift report and communication.
b) Develop and implement a process for shift report review and and clinical support by management staff and/or the charge nurse to ensure completion and appropriate follow up.
c) Provide training to all registered staff, personal support workers and resident support attendants regarding the protocol for shift to shift report.
d) Provide training to all registered nursing staff regarding pain assessments and pain management.
e) Keep a written record of training content, staff and dates completed to ensure that all staff completed the training.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was not neglected.

An anonymous complaint was received by the Ministry of Long-Term Care regarding a resident who suffered an injury when a staff member was pushing them in a wheelchair without footrests on. The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care eleven days after the incident, as Improper/Incompetent treatment of a resident that resulted in harm or risk of harm to a resident. The investigation related to the incident was not initiated until fourteen days after the incident, after inspectors questioned it.

Progress notes for the resident indicated that an incident occurred when the resident's foot went down when being pushed in their wheelchair by staff,

causing the resident extreme pain. This note was not documented until nine days after the actual incident. Staff working on the day of and the days after the incident said the resident reported extreme pain affecting their activities of daily living and that the incident and the pain were reported to registered staff.

There was no shift report for oncoming staff regarding the incident or injury, no documentation in the resident's progress notes and no communication related to the incident or injury for over 24 hours. No pain assessments were completed the day of or the day after the incident. The resident's electronic Medication Administration Records showed pain levels documented as zero on the day of and the day after the incident. No PRN pain medication was administered to the resident on the day of the incident.

The Acting Director of Care (DOC) said that they were informed of the injury the day after it occurred, and that they were not informed of the incident the day prior. Fourteen days later, the Acting DOC said that no investigation of the incident had started as of that date, progress notes had not been reviewed and no staff had been interviewed to determine the cause of the injury or any gaps in care for the resident. The Acting DOC and the Vice President (VP) of Primacare Living Solutions agreed that the lack of assessment, lack of pain management, lack of investigation, lack of action, lack of documentation and lack of communication was neglect of the resident.

Sources: A complaint to the MLTC, a critical incident report, resident health records, observations and staff interviews.

An order was made by taking the following factors into account:
Severity: There was actual harm to resident #015. There was a significant change in condition to the resident.
Scope: The scope of this non-compliance was isolated with only one incident of neglect.
Compliance History: One Voluntary Plan of Correction (VPC) was issued to the home related to the same section of the legislation in the past 36 months. (213)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 15, 2021

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 : 009

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 :

The licensee must be compliant with s. 23 of the LTCHA.
Specifically, the licensee must:
a) Provide training for all applicable staff responsible for completing investigations in the home.
b) Keep a written record of training content, staff and dates completed to ensure that applicable staff completed the training.

Grounds / Motifs :

1. The licensee has failed to ensure that the incident of improper or incompetent treatment or care of a resident, that the licensee was aware of, was immediately investigated and appropriate actions were taken.

An anonymous complaint was received by the Ministry of Long-Term Care regarding a resident who suffered an injury when a staff member was pushing them in a wheelchair without footrests on the wheelchair. The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care eleven days after the incident, as Improper/Incompetent treatment of a resident that resulted in harm or risk of harm to a resident.

The Acting Director of Care (DOC) said that they were informed of the injury the day after it occurred, and that they were not informed of the incident the day prior. Fourteen days later, the Acting DOC said that no investigation of the incident had started as of that date, progress notes had not been reviewed and no staff had been interviewed to determine the cause of the injury or any gaps in care for the resident. Twenty-one days after the incident, the Acting DOC said that there had been no investigation completed related to the use of footrests for that or any other resident in the home.

When the incident was not acknowledged as a critical incident and reported, it was then not investigated and appropriate actions were not taken, which left residents in ongoing risk for injury.

Sources: A complaint to the MLTC, a critical incident report, resident health records and staff interviews.

An order was made by taking the following factors into account:
Severity: There was actual harm to a resident. There was a significant change in condition to the resident.
Scope: The scope of this non-compliance was isolated with only one incident of improper/incompetent treatment.
Compliance History: There was no non-compliance issued to the home related to s. 23 of the legislation in the past 36 months. (213)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 15, 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 16th day of August, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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