Ontario

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

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

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Original Public Report

Report Issue Date: February 9, 2024	
Inspection Number: 2023-1381-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Mon Sheong Foundation	
Long Term Care Home and City: Mon Sheong Richmond Hill Long Term Care Centre, Richmond Hill	
Lead Inspector Marian Keith (741757)	**Inspector Digital Signature**
Additional Inspector(s) Elaina Tso (741750)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 3-5, 8, 10-12, 16-18, 2024
The inspection occurred offsite on the following date(s): January 9, 15, 2024

The following intake(s) were inspected:

- Two intakes related to resident financial abuse.
- An intake related to alleged staff to resident abuse.
- An intake related to a complaint regarding improper transfer.
- An intake related to improper care.
- An intake related to a disease outbreak.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7)

Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.

8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

The licensee has failed to ensure that the use of a physical device to restrain a resident was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were complied with:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Director related to inappropriate use of physical device of a resident.

The resident had multiple health issues and required feeding assistance. The physician had ordered several physical devices as Personal Assistance Services Devices (PASDs) for the resident's safety, comfort, bed mobility, emotional support, and prevention of a behavior. All these physical devices were instructed to be applied few times a day without specific details as per the physician's orders.

The home's closed-circuit television (CCTV) footage on multiple dates showed the resident was being restrained by a physical device on numerous occasions by a Registered Practical Nurse (RPN). The resident was also identified to have other physical devices applied on their upper extremities for every observation and all CCTV footage reviewed. Another RPN indicated that the physical devices for the resident's upper extremities were applied for 24 hours per day. They were released, and the resident were checked every two hours, but the staff did not document this task. Furthermore, the RPN confirmed that the resident was unable to release themself from all these devices. In addition, the RPN indicated that another physical device was applied 24 hours per day, and since the resident also had the physical devices on their upper extremities for 24 hours per day and they were unable to use this physical device.

The home's policy titled, "Minimize Restraining of Residents Policy" defined the "Physical restraints" includes all physical devices used by the home that restrict freedom of movement or normal access to one's body. The use of a physical device from which a resident is both physically and cognitively able to release themselves is not a restraining of the resident. The policy also stating that when a "PASD" (i.e. a device) is being used to restrain a resident rather than to assist the resident with a routine activity of daily living (ADL), it is considered as a restraining device. As per Fixing Long-Term Care Act (FLTCA), 2021, s. 36 (2), "PASD" means personal assistance services device, being a device used to assist a person with a routine ADL.

The Director of Care (DOC) confirmed that all these physical devices were not serving the purpose to assist the resident with any ADL. The DOC further confirmed that the resident was not able to physically and cognitively released any of these devices. In addition, the DOC confirmed that there was no clear instruction in the care plan that indicated how often the staff were to monitor each of the physical

devices when they were being applied. Moreover, the DOC stated that there was no documentation completed when the staff checked and monitored the resident when the physical devices were applied.

The resident's plan of care did not contain any information of how, when to apply and to release the physical devices and how long the physical devices should be on. There was no evidence showing proper assessment and reassessment being done for the resident when they were using the physical devices. There was also no evidence of consent being obtained for these physical devices to be applied as restraints.

Failing to ensure that the use of physical devices as restraints was documented, and the requirements were followed, impacted the resident's freedom of movement, and put them at risk of harm and improper care by staff.

Sources: resident's health records, CCTV footage, home's policy, interviews with the RPN and DOC. [741750]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (6) (b)

Requirements relating to restraining by a physical device
s. 119 (6) Every licensee shall ensure that no physical device is applied under section 35 of the Act to restrain a resident who is in bed, except,
(b) if the physical device is a bed rail used in accordance with section 18.

The licensee has failed to ensure that when the physical devices of bed rails were being used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

Rationale and Summary
A CI report was submitted to the Director related to inappropriate use of physical device of a resident.

The resident had multiple health issues, and required two staff total assistance for bed mobility.

The physician ordered the physical devices as PASD for the resident for over three years to help with their bed mobility and emotional support. There was also another order for the physical devices to be applied on the resident's upper extremities starting three years ago to prevent a behavior. All these physical devices were instructed to be applied few times a day as per the physician's orders.

The resident's care plan indicated to evaluate the PASD use every three months as per facility protocol. The consent for use of PASD for the resident was signed every three months by the registered staff and the Substitute Decision Maker (SDM). The latest quarterly review for use of physical devices was completed and commented that the use of the physical devices PASD for the bed was effective for bed mobility.

The RPN indicated that the physical devices for the upper extremities and the physical devices for the bed were applied for 24 hours per day for the resident. The RPN further confirmed that the resident was unable to release themselves from the physical devices for their upper extremities. The resident had the physical devices

on their upper extremities for 24 hours, and they were unable to use the physical devices for the bed.

There was no proper assessment done for the resident to address their needs for using the physical devices in their bed as the physical devices for their upper extremities were applied to them 24 hours per day and they were unable to use the bed devices. Even when staff removed their upper extremities physical devices for a short period of time while providing care to them, they were rarely able to utilize the devices. The resident required total assistance with their care.

Failing to ensure the resident was properly assessed, the use of bed devices posed potential risk of harm for the resident by improper restraint use.

Sources: resident's health records, interview with the RPN. [741750]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2)

Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member

of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed, and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary, based on the resident's condition or circumstances.

The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 35 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.)
5. That the resident is released and repositioned any other time when necessary, based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the

restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Rationale and Summary
A CI report was submitted to the Director related to inappropriate use of physical device of a resident.

The resident had multiple health issues. The physician had ordered several physical devices as PASDs for the resident's safety, comfort, bed mobility, emotional support, and prevention of a behavior. All these physical devices were instructed to be applied few times a day but no other specific details as per the physician's orders.

The home's CCTV footage on multiple dates showed the resident was being restrained by a physical device on numerous occasions by an RPN. The resident was also observed to have other physical devices applied on their upper extremities in all of the CCTV footage. Another RPN indicated that the physical devices for the resident's upper extremities were applied for 24 hours per day. Furthermore, the RPN confirmed that the resident was unable to release themself from all these devices. In addition, the RPN indicated that the resident's bed devices were applied 24 hours. The resident also had the physical devices on their upper extremities for 24 hours per day and they were unable to use the bed devices.

The home's policy titled, "Minimize Restraining of Residents Policy" defined the "Physical restraints" includes all physical devices used by the Home that restrict freedom of movement or normal access to one's body. The use of a physical device from which a resident is both physically and cognitively able to release themselves is not a restraining of the resident. The policy also stated that when a "PASD" (i.e. a

device) is being used to restrain a resident rather than to assist the resident with a routine ADL, it is considered as a restraining device. As per FLTCA, 2021, s. 36 (2), "PASD" means personal assistance services device, being a device used to assist a person with a routine ADL.

The DOC confirmed that all these physical devices were not serving the purpose to assist the resident with any ADL. The DOC further confirmed that the resident was not able to physically, and cognitively release any of these devices. The Administrator also confirmed that an RPN used the physical device inappropriately to restrain the resident.

The home had been using the different physical devices to restrain the resident without any physician's orders. There was no documentation provided that the resident was being monitored at least every hour, release from physical device and repositioned at least once every two hours. The home continued to believe that they used all these physical devices as PASDs but not as restraints. The resident was not being reassessed and the effectiveness of the restraining was not being evaluated. The home was not following the requirements under the legislation when using these restraints.

Failing to ensure that the requirements were met when using physical restraint with the resident, impacted their freedom of movement and put them at risk of harm, being abused and receiving improper care by staff.

Sources: resident's health records, CCTV footage, home's policy, interviews with the RPN, DOC and Administrator. [741750]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (5)

Requirements relating to restraining by a physical device
s. 119 (5) Where a resident has been restrained by a physical device under section 35 of the Act, or pursuant to the common law duty referred to in section 39 of the Act, and the resident is released from the physical device or the use of the physical device is being discontinued, the licensee shall ensure that appropriate post-restraining care is provided to ensure the safety and comfort of the resident.

The licensee has failed to ensure that when a resident had been restrained by the physical devices, they were released from the physical devices and was being provided appropriate post-restraining care to ensure their safety and comfort.

Rationale and Summary
A CI report was submitted to the Director related to inappropriate use of physical device of a resident.

The resident had multiple health issues. The physician had ordered several physical devices as PASDs for the resident's safety, comfort, mobility, emotional support, and prevention of a behavior. All these physical devices were instructed to be applied few times a day but no other specific details as per the physician's orders.

The home's CCTV footage on multiple dates showed the resident was being restrained by a physical device on numerous occasions by an RPN. The resident was also observed to have other physical devices applied on their upper extremities in all of the CCTV footage. Another RPN indicated that the resident's upper extremities' physical devices and the bed devices were applied for 24 hours per day. The RPN confirmed that the resident was unable to release themselves from all these

physical devices.

The home's policy titled, "Minimize Restraining of Residents Policy" defined the "Physical restraints" includes all physical devices used by the Home that restrict freedom of movement or normal access to one's body. The use of a physical device from which a resident is both physically and cognitively able to release themselves is not a restraining of the resident. The policy also stated that when a "PASD" (i.e. a device) is being used to restrain a resident rather than to assist the resident with a routine ADL, it is considered as a restraining device. As per FLTCA, 2021, s. 36 (2), "PASD" means personal assistance services device, being a device used to assist a person with a routine activity of living.

The DOC confirmed that all these physical devices were not serving the purpose to assist the resident with any ADL. The DOC further confirmed that the resident was not able to physically, and cognitively release any of these devices. The Administrator also confirmed that an RPN used the physical device inappropriately to restrain the resident.

The home had been using different physical devices as restraint for the resident. There was no documentation to prove that the resident was being released from all of these physical devices at least every two hours when they were in use. Moreover, the physical devices for the upper extremities were put on for 24 hours daily, the resident was unable to move their upper extremities freely.

Failing to ensure the appropriate post-restraining care was provided to the resident, caused discomfort, potential risk of skin irritation and infection to their upper extremities as the physical devices prohibited the skin to breathe.

Sources: resident's health records, CCTV footage, home's policy, interviews with the RPN, DOC and Administrator. [741750]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure a resident's right to be afforded privacy when receiving medical intervention from staff.

Rationale and Summary
A CI report was submitted to the Director related to inappropriate physical device use of a resident.

The resident had multiple health issues and required a medical intervention for their diagnosis. The home's CCTV footage on a specific date showed an RPN administered a medical intervention to the resident in a common area without providing any privacy to the resident.

The DOC confirmed that the RPN did not provide privacy to the resident by administering the medical intervention in the common area. The expectation was to administer the intervention in the resident's room to provide them with privacy.

Failing to provide privacy for the resident during a medical intervention did not respect the resident's right to privacy for this intervention as per the Resident's Bill of Rights, as they were unable to provide consent to the location and manner of delivery of the intervention.

Sources: resident's health records, CCTV footage, interview with the DOC. [741750]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 4.

Reporting certain matters to Director
s. 28 (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:
4. Misuse or misappropriation of a resident's money.

The licensee failed to immediately inform the Director of alleged misuse or misappropriation of a resident's funds.

Rationale and Summary:
A CI report was submitted to the Ministry of Long-Term Care (MLTC) for the resident's allegation that their family member removed all of their funds from a financial institute.

The DOC confirmed that the expectation of the home was to immediately report an incident to the Director of misuse or misappropriation of a resident's funds.

Failure to submit the CI report within the expected timeframe had no impact to the

resident.

Sources: CI report, interview with the DOC. [741757]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident's transfer.

Rationale and Summary
A complaint was brought forth to the MLTC related to a resident's injury with unknown cause.

The resident's health records revealed that a physiotherapy assessment was completed on a specific date, and recommended standing pivot transfer with one to two persons assist, and short distance ambulation in room as tolerated. The resident's care plan also indicated that they were one to two persons assist transfer. A Personal Support Worker (PSW) indicated that during the morning care on a specific date, they assessed the resident and determined it was appropriate to use one person assist transfer to get the resident out from the bed to the mobility aid. The PSW confirmed that they transferred the resident on their own by manually lifting them from the bed to the mobility aid. Further, the PSW stated that resident's

feet were not touching the floor during the transfer. The resident was found to have a lower extremity injury later on with unknown cause.

The Physiotherapist (PT) indicated that the resident had no changes to their condition since their last assessment until the incident date. The PT confirmed that the resident was able to bear weight on both feet and they were one to two persons assist transfer. Staff were not to do manual lifting as it was not safe. The expectation was to assess the resident first to determine if an additional staff member was required.

The home's policy, 'Body Mechanism/Lift /Transfer' policy indicated that staff must use correct body mechanics to protect their backs and ensure the safety for both resident and staff.

The DOC confirmed that staff should not perform a manual lifting transfer as the resident was able to weight bear and was not safe to both the resident and the staff. The expectation of the staff was to do the transfer safely.

Failing to use the safe transfer technique put the resident at risk of falls and injuries.

Sources: resident's health records, home's policy, interviews with the PSW, PT and DOC. [741750]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee has failed to ensure that the implementation of interventions to mitigate and manage the nutritional risks for a resident.

Rationale and Summary
A CI report was submitted to the Director related to inappropriate use of physical device of a resident.

The resident had multiple health issues and required feeding assistance. Resident's health record indicated that they had chewing and swallowing problems related to their illness. They were on a modified texture diet.

The CCTV footage on specific dates showed an RPN fed the resident with regular texture food.

The Registered Dietitian (RD) confirmed that the food texture was inappropriate for the resident. The RD further indicated that the home had the resident's prescribed food texture available and if served certain regular textured foods, the food needed to be well soaked in liquid prior to feeding.

There was potential risk of choking and aspiration to the resident as they were not served food of the correct texture.

Sources: resident's health records, CCTV footage, interview with the RD. [741750]

WRITTEN NOTIFICATION: Dining and snack service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that staff used proper techniques to assist a resident who required assistance with eating.

Rationale and Summary
A CI report was submitted to the Director related to inappropriate use of physical device of a resident.

The resident had multiple health issues and required feeding assistance. The resident's health records indicated that they had chewing and swallowing problem related to their illness and staff to allow adequate eating time. The home's CCTV footage on specific dates showed an RPN fed the resident with mouth full of food without giving any time in between for the resident to swallow. Food was observed coming out from the resident's mouth. In addition, on two specific dates, the video clips showed the RPN separately shoved seven and nine spoonful of modified textured food nonstop into the resident's mouth and the food was coming out from the resident's mouth.

The RD also reviewed some of the video clips and confirmed that the feeding was

inappropriate, it was too fast and forced feeding. The RD further indicated that forced feeding was not allowed in their Long-Term Care Home (LTCH). Furthermore, the RD indicated that forced feeding would resulting in high risk of aspiration, pneumonia or even sudden death. The RD indicated that the expectation was to stop and to re-approach if the resident was not cooperative during feeding. However, the RD commented that the resident was cooperative and was in their best status that the RD had ever seen.

Failing to ensure the staff was using proper techniques to feed the resident, increased the risk of aspiration and pneumonia.

Sources: resident's health records, CCTV footages, interview with the RD. [741750]

COMPLIANCE ORDER CO #001 Duty to protect

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

Duty to protect

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

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

The licensee shall:

1). Properly assess the actual needs and the purpose of using each physical device for a resident by an interdisciplinary team including physiotherapist, occupational therapist, registered nurse and physician.

2). Update the physician's orders on all physical devices for a resident with details as per legislative requirement including the type of the physical device to be used, the purpose of using the physical device, when to apply it, how long it should be on and

when to release it.
3). Ensure the plan of care is updated as per the physician's orders on all the physical devices being prescribed for a resident. Ensure the plan of care has clear directions on the application, monitoring, assessment, post-application care and duration of usage for each physical device. Properly document the time when a resident and each physical device are being checked and assessed.
4). The home must provide in-person education to all nursing staff, including registered staff, personal support workers, nursing agency staff, physiotherapist, occupational therapist, all ADOCs, DOC, Administrator and the Physician in the home on Restraints and PASDs. This education must be delivered by a Clinical Educator with extensive knowledge of Restraints and PASDs for Long-Term Care Homes. If the educator is from external source, please also include the documentation with proof of their specialty and title with their full name on it. This education must include, but is not limited to, the definitions of Restraints and PASDs, the differences between Restraints and PASDs, the assessments for Restraints and PASDs, when and how devices are being used as PASDs and when they are being used as Restraints, criteria for orders, consent, care plan, monitoring and documentation for Restraints and PASDs. All education delivery must be documented as to when the education was delivered, who provided the education, handwritten signatures by those in attendance, and the content of this education should be kept with this information, and all of this information should be made available for the inspector upon request.
5). The home must provide in-person education to all nursing staff, including registered staff and personal support workers, and agency nursing staff on Resident's Rights, and the home's Prevention of Abuse and Neglect Program and all related policies. This education must be delivered by a management staff from the home. All education delivery must be documented as to when the education was delivered, who provided the education including their full name and title, full name, title and handwritten signatures by those in attendance, and the content of this

education should be kept with this information, and all should be made available for the inspector upon request.
6). The home must conduct monitoring of the identified resident home area (RHA) dining room for every meal (breakfast, lunch and dinner) for a period of four weeks. The monitoring must be conducted by a member of the nursing or nutrition management team being present in the dining room, and this must be documented with handwritten signatures, full name and title by those completing the monitoring, the date and time of the monitoring. For every meal, the management staff must complete an audit for a resident that includes the resident's diet texture received, proper meal assistance techniques, safe positioning and restraint use during the meal, and document any education and or corrective measures taken during the audit. All audits should have handwritten signatures of those completing the audits. Analysis of the audits must be conducted, and any corrective actions documented. The audits and analysis results, education records and monitoring records should be made available for inspectors upon request.
7). The home must review and analyze their CCTV video surveillance in the dining area for the identified resident home area (RHA) for all meals (breakfast, lunch and dinner) for a period of two weeks after the completion of the four weeks in-person monitoring to further monitor for restraint use, diet texture, proper feeding techniques and safe positioning for a resident during mealtime in the dining room. The CCTV video review need to be done by a management member. Provide a summary of each CCTV video review and document with handwritten signatures by those conducting the monitoring and when the monitoring occurred. The monitoring records should be made available for inspectors upon request.
8). The home must develop and implement a process to monitor the CCTV videos on a monthly basis by the home's management team.
9). The home must provide in-person education to all nursing staff, including registered staff and PSWs on the identified RHA on the home's Nutritional Program, specifically on diet textures, proper techniques to assist residents with eating, safe

positioning of residents who require meal assistance, documenting intake and the home's policies associated with these components, and infection prevention and control as it relates to handling residents' food in the dining room. This education must be delivered by the Registered Dietitian or food service manager. All education delivery must be documented as to when the education was delivered, who provided the education that includes the trainer's full name and title, full name, title and handwritten signatures by those in attendance, the content of this education should be kept with this information, and all should be made available for inspectors upon request.
10). Administer a supervised, test to all staff post training. Ensure all staff are completing testing independently and without aid. Ensure that any staff receiving a final grade of less than 85% on the test is provided with retraining and is retested on the materials. Maintain a documented record of the test materials and content, the administration record, and the final grades for each participant as well as the date the test was administered.

Grounds
The licensee has failed to ensure that a resident was being protected from being abused by the staff.

Rationale and Summary
A CI report was submitted to the Director related to inappropriate use of physical device of a resident.

The resident was cognitively impaired, unable to communicate and required feeding assistance. The resident's health record indicated that they had a physical device as a PASD for safety and promote comfort when they were up in their mobility aid. The home's CCTV footage on several specific dates showed an RPN used the physical device to restrain the resident's upper extremities on numerous

occasions during care. The resident was cooperative, and they had no responsive behavior shown in the CCTV footage. In addition, the CCTV footage on a specific date also showed the RPN was sharing food and drink from the resident to a co-resident and took food from the co-resident to feed the resident. The RPN also took the used eating utensil from the co-resident to feed the resident. In addition, the RPN did not perform hand hygiene prior to feeding and prior to administration of a medical intervention to the resident. Moreover, the RPN was administering a medical intervention in the common area without privacy which violated the resident's bill of rights.

The home's investigation records indicated that the RPN admitted that they misused the physical device to restrain the resident to prevent them from moving during care and that was not permitted. Another RPN confirmed that the resident did not have a physician's order for a physical restraint by using the identified physical device. The RPN further indicated that it was easy to manage the resident's upper extremities movement by re-approach, feeding technique and to ensure the food temperature was not too hot.

The Administrator confirmed that the RPN was not following the physician's PASD order and the home's PASD and abuse policy when they applied the physical device over the resident's upper extremities.

Failing to ensure that the resident was protected from being abused by a staff, the resident was impacted negatively, and was at risk for further incidents.

Sources: observation, resident's health records, home's policies, CCTV footage, interviews with the RPN and Administrator. [741750]

This order must be complied with by June 14, 2024.

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
CO #001 of Inspection #2021-715672-0003, LTCHA, 2007 s. 19 (1)

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

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control (IPAC). O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1). Retrain PSW #101 on when and how to assist residents with hand hygiene, the correct procedures of donning and doffing PPE for additional precautions by the IPAC lead.
2). Maintain a written record of training including the training materials, the date of training, name of staff attending with signature of the staff indicating understanding of training received, the name and title of the staff who provides the training.
3). Conduct an audit once per shift for PSW #101 on IPAC practices related to assisting residents with hand hygiene and donning and doffing PPE for 14 shifts by a registered staff and/or the IPAC lead. Analyze the audit results and provide on the spot education and/or corrective actions to PSW #101 if any concerns are identified. Maintain a record of the audit and results, any education or corrective actions provided including the name and title of the auditor, the date and time of the audit being conducted.
4). Administer a supervised test to PSW #101 post training. Ensure PSW #101 completes the test independently and without aid. Ensure that if PSW #101 receives a final grade of less than 85% on the test, they are provided with retraining and is

retested on the materials. Maintain a documented record of the test materials and contents, all test results, the final grade as well as the date(s) the test(s) was administered.
5). Provide records identified from the above number one to number four and PSW #101's work schedule corresponding to the audit immediately upon request by inspectors.

Grounds
1). Non-compliance with: O.Reg. 246/22, s. 102 (2) (b), IPAC Standard section 10.4 (h)

The licensee has failed to ensure that any standard issued by the Director with respect to IPAC was complied with. Specifically, a PSW failed to support residents with hand hygiene prior to their meals.

Rationale and Summary:
In accordance with the IPAC Standard for Long-Term Care Homes, April 2022, Additional Requirements Under the Standard, section. 10.4 directs the licensee to ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as, under section 10.4 (h) support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

The LTCH was in a communicable disease outbreak during the inspection. Inspector #741750 observed a PSW was providing lunch tray service to two residents but did not assist the residents in performing hand hygiene prior to receiving their meals.

The PSW confirmed that they did not help the residents to perform hand hygiene before their meals. The IPAC lead confirmed that their expectation was to assist residents to perform hand hygiene before meals.

Failure to comply with the IPAC standard requirement to support residents with hand hygiene prior to meals increased the risk of transmission of germs or infectious agents.

Sources: observation, residents' health records, home's policy, CI report, interviews with the PSW and IPAC Lead. [741750]

2). Non-compliance with O. Reg. 246/22, s. 102 (2) (b), IPAC Standard section 9.1 (f)

The licensee failed to ensure that any standard issued by the Director with respect to IPAC was complied with. Specifically, a PSW did not properly remove the PPE after providing care to residents with additional precautions.

Rationale and Summary
In accordance with the IPAC Standard for Long-Term Care Homes, dated April 2022, section 9.1 (f) directs the licensee to ensure that Routine Practice and Additional Precautions are followed in the IPAC Program. At minimum, Additional Precautions shall include appropriated selection, application, removal and disposal of Personal Protective Equipment (PPE).

The LTCH was in a communicable disease outbreak during the inspection. Two identified residents' health records indicated that they were tested positive for the communicable disease. There was signage at both residents' doors indicating they were on additional precautions. Inspector #741750 observed a PSW exiting a resident's room without doffing their face shield nor their N95 respirator and entered another resident's room with the same face shield and N95 respirator. After providing care to that resident, the PSW exited their room, and wore the same face shield and N95 respirator to enter other resident's room.

The PSW confirmed that they did not remove their face shield nor their N95 respirator after they provided care to the two identified residents with communicable disease. The IPAC lead stated that staff were expected to remove the face shield and the N95 respirator after used and to put on a new set to enter other resident's room.

Failure to comply with the IPAC Standard requirement to proper doffing the PPE increased the risk of transmission of communicable disease to themselves, other residents, and staff.

Sources: observation, resident's health records, home's policies, CI report, interviews with the PSW and IPAC Lead. [741750]

3). Non-compliance with O. Reg 246/22, s. 102 (2) b, IPAC Standard section 9.1 (b)

The licensee failed to ensure that staff hand hygiene is being performed as per Routine Practices and the Infection Prevention and Control Program.

Rationale and Summary
In accordance with the IPAC Standard for Long-Term Care Homes, April 2022, Routine Practices Under the Standard, section. 9.1 (b) directs the licensee to ensure that hand hygiene is performed, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

When reviewing the home's CCTV footage on a specific date, an RPN was observed not performing hand hygiene prior to assisting a resident and another resident with meals and prior to medication administration for a resident.

The home's relevant policy indicated step one was to perform hand hygiene.

The DOC also reviewed the same CCTV footage and confirmed that the RPN did not perform the hand hygiene prior to assisting the resident with their meal and prior to administering medication. The expectation was to perform hand hygiene first prior to performing both tasks.

Failing to perform hand hygiene before contacting residents would increase risk of transmitting pathogens to residents and put residents at risk of infection.

Sources: resident's health records, home's policy, CCTV footage, interview with the DOC. [741750]

This order must be complied with by June 14, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

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

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same

requirement.

Compliance History:
CO #002 of Inspection #2022-1381-0001, O. Reg. 246/22, s. 102 (2) (b)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

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

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

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

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

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

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