Ontario

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

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date August 19, 2022
Inspection Number 2022_1258_0001
Inspection Type **Critical Incident**

☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Shanti Enterprises Limited

Long-Term Care Home and City
Royal Terrace, Palmerston

Lead Inspector
Robert Spizzirri (705751)

Additional Inspector(s)
Henry Chong (740836)

Inspector Digital Signature
Robert Spizzirri
Digitally signed by Robert Spizzirri
Date: 2022.08.19 10:44:34 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 9-12, and 15-16 of 2022.

The following intake(s) were inspected:

- Intake # 011292-22 related to fall prevention and management.
- Intake # 018438-21 related to an alleged incident of abuse.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION [DIRECTIVES BY MINISTER]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 184 (3)

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In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective April 27, 2022, Licensees are required to ensure that the personal protective equipment requirements as set out in the COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, or as amended, are followed.

According to the COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, revised June 26, 2022, appropriate eye protection is required for all staff when providing care to residents with suspect/confirmed COVID-19 in an outbreak area.

Two staff provided care to a resident isolated for suspected COVID-19, in an outbreak area, without wearing eye protection. There was signage on the resident's door identifying additional precautions and the need for eye protection.

Both staff said that they were not aware they had to wear eye protection.

Other staff stated they received their communication from the signs posted above resident rooms.

There was risk of increased transmission of COVID-19 when staff failed to wear the appropriate PPE.

Sources: Minister's Directive: COVID-19 response measures for long-term care homes (Effective April 27, 2022), observations and interview with staff.

[705751]

WRITTEN NOTIFICATION [REPORTING CERTAIN MATTERS TO DIRECTOR]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24 (1) (2)

The licensee has failed to ensure that when they had reasonable grounds to suspect a resident had been abused, that it was immediately reported to the Director.

A resident informed the home that there was an altercation between themselves and a staff member which they alleged resulted in an injury.

The Administrator said there was suspicion of abuse.

The home did not inform the Director immediately.

Failure of the home to immediately report the alleged abuse could have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Critical Incident Report, Resident's progress notes, interview with Administrator and other staff.

[705751]

WRITTEN NOTIFICATION [RESIDENTS' BILL OF RIGHTS]

NC#0 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 3 (1) 1.

The licensee has failed to ensure that a resident was treated with courtesy and respect.

A resident reported that a staff member attempted to force them to attend a meal, against their wishes.

The home completed an internal investigation which concluded that staff did not respect the resident's right to make a decision.

The Administrator said that Resident's Bill of Rights were not respected.

The resident did not feel respected when staff attempted to force them to attend a meal against their wishes.

Sources: The home's internal investigation notes, employee records, Resident's progress notes, interviews with Administrator and other staff.

[705751]