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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date July 20, 2022
Inspection Number 2022_1580_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
City of Toronto

Long-Term Care Home and City
Seven Oaks LTCH, Scarborough

Lead Inspector
Jennifer Batten #672

Inspector Digital Signature
Jennifer Batten RN

Additional Inspector(s)
Holly Wilson #741755 (present during inspection)

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 7, 8, 9, 10, 13, 14, 15, 16 and 17, 2022

The following intake(s) were inspected:

One intake related to following up on a previous Compliance Order from inspection #2022_941746_0006, regarding s. 131 (2) with a CDD of May 2, 2022.

One intake related to the attempted suicide of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	s. 131 (2)	#2022_941746_0006	001	Amandeep Bhela #746

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)

- Medication Management
- Prevention of Abuse and Neglect
- Residents' Rights and Choices
- Responsive Behaviours
- Safe and Secure Home

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with O. Reg. 246/22 r. 12

The licensee has failed to ensure that all doors which led to the outside of the home were kept closed and locked.

Rationale and Summary:

While conducting the initial tour of the home, Inspectors observed a door to a non-residential area was left propped open. This door was noted to be on the main floor of the home, just outside of the dementia care resident home area (RHA). The door was also located close to the elevators, which multiple residents were noted to use, and residents were observed to be in the immediate area. The Inspectors went down the hall and noted it led to a door which led to the outside, that had also been left propped open by a shovel. Inspectors immediately brought this to the attention of the management team of the home, who indicated there were currently several teams of contractors working throughout the home, completing tasks such as painting, plumbing and flooring. They further indicated they would discuss this with the contracting teams to ensure it did not occur again.

By not ensuring that all doors which led to the outside of the home were kept closed and locked, unsupervised residents may have had an opportunity to wander into the non-resident area and outside of the long-term care home (LTCH).

Throughout the rest of the inspection dates completed in the home, the door was not seen to be left propped open again.

Date Remedy Implemented: June 7, 2022 [672]

WRITTEN NOTIFICATION – DINING AND SNACK SERVICES

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22 r. 79 (1) 10

The licensee failed to ensure that appropriate furnishings, including comfortable dining room chairs at an appropriate height to meet the needs of the resident were used.

Rationale and Summary:

Resident #018 was observed eating their lunch meal while seated in a wing-backed lounge chair in the lounge area of the resident home area (RHA). The lounge chair was noted to be seated quite low and the overbed table which was being utilized as a dining table was high above the chair and the resident. This caused the resident to need to lean forward significantly and reach up, in order to access their food and fluid items, and was noted to struggle to reach all of the items on the overbed table. Registered Nurse (RN) #123 indicated approximately one third of the residents who resided on the RHA had been eating all of their meals in the lounge area since the pandemic, in order to assist with the physical distancing of the residents. RN #123 further indicated resident #018 “always” ate their meals in the same lounge chair, as the resident preferred to be sitting by the television, if they were no longer able to eat within the dining room. RN #123 indicated that other options for resident #018’s seating options during meals had not been explored and verified the lounge chair did not allow for the resident to be seated in an upright position during food and fluid intake. On two later dates, resident #018 was again observed sitting in the lounge chair in front of the television during their meal and snack services.

During separate interviews, the Acting Nutrition Manager, Nutrition Manager and DOC each indicated the expectation in the home was for every resident to be seated in a chair which met the resident’s needs and was comfortable for the resident during all meals and snack services. The chairs were also expected to allow for the residents to remain in a safe, upright position during all intake of food and fluids.

By not ensuring that appropriate furnishings, including comfortable dining room chairs at an appropriate height to meet the needs of the resident were used during food and fluid intake, residents were placed at risk of experiencing physical discomfort, which may lead to the resident not completing their full meal, including all fluids served. Inappropriate dining chairs which don’t meet the needs of the resident may also place them at risk of choking and/or aspiration.

Sources: Observations conducted on June 10, 13 and 14, 2022; resident #018’s current plan of care; interviews with RN #123, the Acting Nutrition Manager, Nutrition Manager and DOC.

WRITTEN NOTIFICATION – DINING AND SNACK SERVICES

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22 r. 79 (1) 5

The licensee has failed to ensure that meals were served at both safe and palatable temperatures for the residents.

Rationale and Summary:

The Inspectors conducted observations on June 7 to 10, and 13 to 17, 2022, and noted the lunch meal service started at approximately 1200 hours. The Licensee's internal policies related to nutrition and hydration indicated that the acceptable range for cold food was 4.0 degree Celsius (°C) or 40.0-degree Fahrenheit (F) or less and for hot food was 60.0 °C or 140.0 F or more. The food service worker (FSW) and/or cook were to record the food temperature and take appropriate corrective actions before service.

During one of the lunch meals, Inspector noted that resident #016 had their meal served to them on their bedside table prior to a staff member being available to provide the required assistance. The meal consisted of soup, turkey, vegetables, and bread.

Inspector observed the resident was still waiting for assistance with their meal at 1249 hours, therefore assessed the temperatures of each of the food items prior to the resident consuming the meal and noted the following:

Soup temperature – 62.0 °C
Entrée temperature – 49.3 °C
Vegetable temperature – 18.5 °C

PSW #124 arrived at 1307 hours to assist the resident with their lunch meal but did not offer to reheat the meal prior to serving it to the resident, despite the meal sitting out for a minimum of 18 minutes.

On two later dates, Inspector noted that residents #011 and #016 had their meal trays already made up with their soup and ice cream desserts. The trays were sitting in the dining room, waiting to be served to the residents in their bedrooms. Inspector noted that the ice cream desserts appeared to be melted and the soup cups and meal plates no longer felt warm to the touch. FSW #128 verified they frequently prepared meal trays ahead of time with the desserts and soups, so the PSW staff only had to get the meal plated in order to take the tray to the residents receiving tray service for that meal.

Following the above observations, Inspector noted that resident #016 again had their meal served to them on their bedside table at 1240 hours, prior to a staff member being available to provide the required assistance. The meal consisted of soup, meat with gravy and vegetables. Inspector assessed the temperatures of each of the food items at 1252 hours, prior to the resident consuming the meal and noted the following:

Soup temperature – 62.5 °C
Entrée temperature – 40.0 °C
Vegetable temperature – 39.5 °C

During an interview, the Nutrition Manager indicated the expectation in the home was for meals to be served to residents only when a staff member was available to provide the required assistance with the meal. This was to assist in ensuring all meals were served at both safe and palatable temperatures for the residents. The Nutrition Manager further indicated staff were able to reheat any food items and/or dispose of the food items and request a new meal.

By not ensuring meals were served to residents at safe and palatable temperatures, there could be negative effects on the residents, such as decreased intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; internal policies related to meal service temperature recording; interviews with RPN #131, FSWs #128 and #129, the Nutrition Manager and DOC.

WRITTEN NOTIFICATION – DINING AND SNACK SERVICES

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 246/22 r. 79 (2) b

The licensee has failed to ensure that residents who required assistance with eating and drinking, were not served their meal until someone was available to provide the assistance required by the resident.

Rationale and Summary:

Inspectors conducted resident observations during meal services. On an identified date and time, Inspector noted that resident #014 had their lunch meal served in front of them, uncovered, on the dining room table. No staff member appeared to be assisting the resident or were available to provide the required assistance. PSW #122 indicated resident #014's meal had been served with the meals for the co-residents at the table and they would provide the required assistance to the resident with their meal once they were finished assisting another resident. PSW #122 was observed to begin assisting resident #014 with their meal at 1227 hours.

On two occasions, Inspector noted that resident #016 had their lunch meals served to them on their bedside table prior to a staff member being available to provide the required assistance.

By not ensuring residents were not served their meals until a staff member was available to provide the required assistance,

Sources: Observations conducted; interviews with PSW #122, RPN #131, FSWs #128 and #129, the Nutrition Manager and DOC.

COMPLIANCE ORDER CO#001 – MEDICATIONS

NC#005 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: FLTCA, 2021 s. 140 (2)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 140 (2) of FLTCA 2021.

Specifically, the Licensee must:

Ensure that insulin administered to resident #008 is in accordance with the directions for use specified by the prescriber.

Grounds

Non-compliance with O. Reg. 246/22 r. 140 (2)

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 131 (2) of O. Reg. 79/10/LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 140 (2) of O. Reg. 246/22 under the FLTCA.

A previous Compliance Order (CO #001) was issued to the licensee related to O. Reg. 79/10, s. 131 (2) during inspection #2022_941746_0006, on March 22, 2022, with a compliance due date of May 2, 2022. The Compliance Order could not be complied and will remain in place for the following reasons:

The licensee failed to ensure that drugs were administered in accordance with the directions for use specified by the prescriber for resident #008.

Rationale and Summary:

Resident #008's clinical records indicated that they had a medication order for an identified medication. The medication order provided specific directions for staff to administer the medication. Review of resident #008's electronic Medication Administration Record (eMAR) and progress notes from an identified period of time indicated there were 17 incidents of the medication not being administered in accordance with the directions for use specified by the prescriber.

The Director of Care (DOC) indicated the expectation in the home was for staff to ensure they always administered medications to residents according to the directions for use specified by the prescriber. Inspectors reviewed the findings of noncompliance with the DOC, and they agreed that on those occasions, resident #008's medication was not administered according to the directions specified by the prescriber.

By not ensuring that resident #008 received their medication as ordered, they were placed at risk of experiencing adverse events and other serious conditions.

Sources: Resident #008's identified eMARs, physician's orders and quarterly assessment and written plan of care; mealtime schedule for the home; interviews with RPN #119, Nurse Manager #005 and the DOC.

This order must be complied with by August 19, 2022

COMPLIANCE ORDER CO #002 – MEDICATIONS

NC#006 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 138

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 139 (1) of FLTCA 2021.

Specifically, the Licensee must:

Conduct daily audits of resident home areas for a period of two weeks to ensure medication and treatment carts are kept secured and locked at all times when not being used or supervised and medicated treatment creams are not left in resident rooms. If the practices are noted, provide immediate redirection and re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

Grounds

Non-compliance with O. Reg. 246/22 r. 139 (1)

The licensee failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies, which was kept secured and locked.

Rationale and Summary:

During the initial tour of the home, Inspectors observed medicated treatment creams in identified residents' bedrooms, on top of dressers and/or television stands. Each resident was in separate, shared bedrooms and there were other residents wandering in the RHA. Review of the resident's physician's orders and identified electronic Medication Administration Record (eMAR) indicated the medicated treatment creams were to be applied by staff.

On one occasion, Inspectors observed the medication cart on the fourth floor to be parked in the lounge area beside the nursing station, unlocked. Inspectors noted there were 21 residents in the immediate area, with no staff members present, as it appeared to be shift change. Inspectors were able to open each drawer of the medication cart and access all medications without being observed and/or questioned.

On another occasion, Inspectors observed a treatment cream parked in the lounge area of the fifth floor which had been left unlocked. Inspectors noted there were multiple residents in the immediate area, with no staff members present. Inspectors were able to open each drawer of the treatment cart, which stored medicated treatment creams for the residents who resided on the RHA. On the same date, Inspectors observed several medicated treatment creams in a resident's bedroom. Review of their physician's orders and eMAR indicated the medicated treatment creams were to be applied by staff.

The Nurse Managers for the 4th and 5th floors and the DOC verified the expectation in the home was for medications and medicated treatment creams to be kept secured and locked at all times in the appropriate administration cart when not being utilized by staff. This included ensuring medication and treatment carts were kept secured and locked when not in use and within sight of the responsible Registered staff member.

By not ensuring drugs were stored in an area or medication/treatment cart which was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted; interviews with RPNs #115, and #119, Nurse Managers for the 4th and 5th floors and the DOC.

This order must be complied with by August 19, 2022

COMPLIANCE ORDER CO#003 - DINING AND SNACK SERVICES

NC#007 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 r. 79 (1) 9

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with r. 79 (1) 9 of O.Reg. 246/22

Specifically, the Licensee must:

Conduct daily audits of meal services for a period of two weeks to ensure safe positioning during meals of residents #009, #012, #014, #015, #017, #020, #024 and #025 is occurring. Audits are to include all residents eating their meals outside of the dining room. If unsafe positioning is noted, provide immediate redirection and re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

Grounds

Non-compliance with O. Reg. 246/22 r. 79 (1) 9

The licensee failed to ensure that proper techniques, including safe positioning, were used to assist residents #009, #012, #014, #015, #017, #020, #024 and #025, who each required assistance with eating.

Rationale and Summary:

Resident #009 was observed eating their lunch meal while not seated in an upright position. RPN #117 indicated that was the position the resident was always in, even during food/fluid intake. Following the interview, RPN #117 allowed Inspector to reposition the resident into an upright position for the remainder of the meal, with permission from resident. On a later specified date, resident #009 was again observed eating their lunch meal while being assisted by PSW #116 and not seated in an upright position. PSW #116 indicated that was the position the resident was always in, even during food/fluid intake.

On an identified date and time, resident #012 was observed being assisted with their lunch meal by PSW #118 while not seated in an upright position. PSW #118 indicated that was the position the resident was always in, even during food/fluid intake. On a later identified date, resident #012 was again observed eating their lunch meal while being assisted by PSW staff and not seated in an upright position. The PSW indicated that was the position the resident was always in, even during food/fluid intake.

On an identified date, resident #014 was observed being assisted with their lunch meal by PSW staff while not seated in an upright position. The PSW indicated that was the position the resident was always in, even during food/fluid intake.

On an identified date, resident #015 was observed being assisted with their lunch meal by PSW #116 while not seated in an upright position. PSW #116 indicated that was the position the resident was always in, even during food/fluid intake. On a later identified date, resident #015 was again observed eating their lunch meal while being assisted by PSW #116 and not seated in an upright position. On a third identified date, resident #015 was observed eating their lunch meal while being assisted by PSW #122 and not seated in an upright position. The PSW indicated that was the position the resident was always in, even during food/fluid intake. On a fourth identified date, resident #015 was observed eating their lunch meal while not seated in an upright position. The PSW and RPN #131 indicated that was the position the resident was always in, even during food/fluid intake.

On an identified date, resident #017 was observed being assisted with their lunch meal by PSW staff while not seated in an upright position. The PSW verified that was not the position the resident was usually in during food/fluid intake and repositioned the resident into an upright position, to continue with the meal.

On an identified date and time, resident #020 was observed being assisted with their lunch meal by PSW staff while in their bed, not in an upright position. PSW indicated that was the position the resident was always in, even during food/fluid intake, which was supported by the resident's care plan due to a specified reason. The resident's health care record and current written plan of care indicated they were required to be positioned at a 90-degree angle during all food and fluid intake and staff were to ensure the resident remained in an upright position for 30 minutes following meals.

On an identified date and time, resident #024 was observed eating their lunch meal while in their bed, not in an upright position. Resident #024 indicated to Inspectors that they frequently took their lunch meal in bed, and staff never changed the positioning of the bed during their food and fluid intake, nor did they remain in the room to observe the resident during meals or recommend a different position for the resident during meal and snack services.

On an identified date, resident #025 was observed being assisted with their lunch meal by PSW #133 while not seated in an upright position. PSW #133 indicated that was the position the resident was always in, even during food/fluid intake.

During the meal observations, Inspector also observed some staff members assisting residents with their intake while standing above the residents instead of being seated beside them. The Nutrition Manager, Acting Nutrition Manager, Nurse Manager and DOC indicated the expectation in the home was for staff members to be seated beside the resident while assisting with food intake and for all residents to be seated in a safe position during food and fluid intake.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; residents #009, #012, #014, #015, #018, #020 and #024's current written plans of care and MDS assessments; interviews with PSWs #116, #118, #122; RPN #131, the Nutrition Manager, Acting Nutrition Manager, Nurse Manager and DOC.

This order must be complied with by August 19, 2022

COMPLIANCE ORDER CO#004 – FALLS PREVENTION

NC#008 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 79/10 r. 8 (1) b

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with r. 8 (1) b of O.Reg. 79/10 and O.Reg 246/22.

Specifically, the Licensee must:

1) Educate all Registered Staff on the internal Suspected Head Injury form and policy, along with the expectations of how/when to complete the document. Keep a record of the education completed, along with the sign in sheet to ensure all staff were captured. Make available for Inspectors upon request.

2) Ensure that when resident #022 falls and head injury routine is required, the assessment is completed in full, as required.

Grounds

Non-compliance with O. Reg. 246/22 r. 11 (1)

The licensee has failed to ensure the internal Suspected Head Injury policy was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 48 (1) the falls prevention and management program is a required organized program in the home.

O. Reg. 79/10, r. 49 (2) states that every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On April 11, 2022, the Fixing Long Term Care Act, 2021 (FLTCA) and O. Reg. 246/22, came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's noncompliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under r.8 (1)(b) of O. Reg. 79/10. Noncompliance with the applicable requirement also occurred after April 11, 2022, which falls under r. 11 (1) b of the FLTCA

Rationale and Summary:

Non-compliance with r. 8 (1) (b) of O. Reg. 79/10 under the LTCHA:

Review of the internal policy related to suspected head injuries indicated that when a resident was placed on head injury routine assessment, staff were to use a specified form, and follow the timeframes indicated within the assessment.

Resident #022 was noted to be at an identified risk for falling. On a specified date, the resident sustained a fall which resulted in head injury routine being required. Upon review of the head injury routine assessment, Inspector noted it had not been completed in full, as per the directions listed within the internal policy and/or on the head injury routine neurological assessment. Staff documented in the assessment they had not assessed the resident as required, due to the resident being asleep. Inspector then reviewed the other head injury routine assessments completed for resident #022 within a specified timeframe and noted those assessments had also not been completed as directed within the internal policy.

Non-compliance with r. 8 (1) (b) of O. Reg. 79/10 under FLTCA:

On a specified date, resident #022 sustained a fall which resulted in head injury routine and neurological assessments being implemented. Upon review of the head injury routine assessment, Inspector noted it had not been completed in full, as per the directions listed within the internal policy and/or on the head injury routine neurological assessment.

RPN #131 indicated it was a known practice in the home for Registered staff to, at times, not complete head injury routine assessments in full, if they believed the resident was stable and presented as sleeping. Nurse Manager (NM) #005 and the DOC indicated the expectation in the home was for the internal suspected head injury policy to be followed, and staff were to complete the head injury routine assessments in full at all times.

By not ensuring head injury routine assessments were completed appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Identified Critical Incident Report; resident #022's head injury routine neurological assessments completed within an identified timeframe; internal policy related to suspected head injuries and interviews with Nurse Manager #005 and the DOC.

This order must be complied with by August 19, 2022

COMPLIANCE ORDER CO#005 – RESIDENT ABUSE AND NEGLECT

NC#009 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 24 (1)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 24 (1) of the LTCHA 2007.

On April 11, 2022, the Fixing Long Term Care Act, 2021 (FLTCA) and O. Reg. 246/22, came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's noncompliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s.24 (1) of the LTCHA 2007.

Specifically, the Licensee must:

Educate Nurse Manager #001 on the internal policy related to zero tolerance of abuse and neglect and the legislation specific to reporting every allegation of resident abuse and/or neglect. Keep a documented record of the education completed and make available for Inspectors, upon request.

Grounds

Non-compliance with s. 24 (1) of the LTCHA 2007

The licensee failed to ensure that the person who had reasonable grounds to suspect the abuse of a resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director related to an alleged incident of a resident exhibiting a responsive behaviour. The resident's progress notes indicated they made an allegation to RPN #134 that they had been physically and emotionally abused by a family member during a visit, and no longer wanted the family member to be allowed to visit with them privately in their bedroom. RPN #134 notified Nurse Manager (NM) #001 of the allegation. There was no evidence nor documentation to indicate the licensee submitted a report to the Director regarding the resident's allegation.

NM #001 verified they had been notified of the resident's allegation of abuse. NM #001 indicated they were aware of the requirements to inform the Director of every alleged incident of resident abuse, would have been the responsible staff member to inform the Director of the resident's allegation and verified the notification had not been completed as required. The DOC indicated all staff who worked in the home were provided with education on the prevention of resident abuse and neglect annually, which included instructions for the Director to be immediately notified of every allegation of resident abuse and/or neglect.

By not ensuring the Director was notified of every allegation of resident abuse and/or neglect, residents were placed at risk of not having every allegation reviewed.

Sources: Critical Incident Reporting system; after hours INFOLine documentation; the resident's progress notes and interviews with Nurse Manager #001 and the DOC.

This order must be complied with by August 19, 2022

COMPLIANCE ORDER CO#006 – RESIDENT ABUSE AND NEGLECT

NC#010 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 23 (1)(a)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 23 (1)(a) of the LTCHA 2007.

Specifically, the Licensee must:

Educate Nurse Manager #001 on the internal policy related to zero tolerance of abuse and neglect and the legislation specific to immediately investigating every allegation of resident abuse and/or neglect. Keep a documented record of the education completed and make available for Inspectors, upon request.

Grounds

Non-compliance with s. 23 (1) (a) of the LTCHA 2007

On April 11, 2022, the Fixing Long Term Care Act, 2021 (FLTCA) and O. Reg. 246/22, came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's noncompliance with the

applicable requirement occurred prior to April 11, 2022, where the requirement was under s.23 (1) (a) of the LTCHA.

The licensee failed to ensure that every alleged incident of resident abuse was immediately investigated.

Rationale and Summary:

A Critical Incident Report was submitted to the Director related to an alleged incident of a resident exhibiting a responsive behaviour. The resident's progress notes indicated that on four separate dates, the resident reported to RPN #134 they had been/were being physically and emotionally abused by a family member. The progress notes stated the resident alleged that following a visit with the family member in their bedroom, they had been abused. Due to the abuse, the resident no longer wanted the family member to be allowed to visit privately in their bedroom. RPN #134 reported the allegation to NM #001 following the resident report. The following day the documentation indicated the resident reported to RPN #134 they were experiencing negative feelings regarding the alleged incidents of abuse. RPN #134 brought the resident to a common area so they could be observed and supported. The progress notes further indicated that the abuse they had sustained from their family member made them exhibit identified responsive behaviours and several days later exhibited that responsive behaviour and were transferred to hospital for further assessment and intervention. The progress notes further indicated that following RPN #134's report to NM #001, they did not follow up with the resident until more than two days after the alleged incident.

NM #001 verified they had been notified of the resident's allegation of abuse from RPN #134 on the day the resident reported the allegation. NM #001 indicated they had not followed up with the resident until two days later, as the initial allegation occurred on a weekend, and they were not in the home again until Monday. NM #01 stated they were aware of the legislative requirement which directed every allegation of resident abuse and/or neglect must be immediately investigated.

By not ensuring every allegation of resident abuse and/or neglect was immediately investigated, residents were placed at risk of possibly experiencing further incidents of resident abuse and/or neglect.

Sources: The resident's progress notes, Critical Incident Report, internal investigation notes and interview with Nurse Manager #001.

This order must be complied with by August 19, 2022

COMPLIANCE ORDER CO#007 – PERSONAL SUPPORT SERVICES

NC#011 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 6 (4)(a)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 6 (4)(a) of the FLTCA 2021.

Specifically, the Licensee must:

Ensure that the physiotherapy staff, occupational therapy staff and RPNs #119 and #131 collaborate with the multidisciplinary team regarding resident #022's mobility aids, to ensure the resident always has an option available to assist them to get up and exit their room on a daily basis, should they wish to do so.

Grounds

The licensee has failed to ensure that staff and others involved in resident #022's care collaborated with each other, to ensure the assessments were consistent with and complemented each other.

Rationale and Summary:

A CIR was submitted to the Director related to an alleged incident of resident #022 exhibiting an identified behaviour. The progress notes indicated the resident had a history of exhibiting the responsive behaviour. The resident was able to provide to Inspectors several reasons for their feelings and exhibited behaviours. The resident indicated to Inspectors they were experiencing the same feelings again. The resident felt the feelings they were experiencing were related to their mobility devices being broken, which caused them to have to remain in their bedroom for a specified length of time. Resident #022 further indicated they were unaware of what was occurring to rectify this situation, as no one had discussed the plan with them.

Resident #022's progress notes and assessments indicated the Occupational Therapist (OT) documented one of the resident's mobility devices was broken. The next assessment related to the resident's mobility device was from more than two months later, which documented that staff were requesting for resident #022 to receive a replacement while waiting for a mobility device to be received. The Physiotherapist (PT) documented that securing a replacement for the resident's mobility device was "a time-consuming process" and the resident could use a different mobility device they owned in the mean time. There were no referrals or assessments noted which indicated resident #022's other mobility device was also broken and could not be used in the interim, while waiting for replacement parts for the initial mobility device.

During separate interviews, the PT, OT and RPNs #119 and #131 indicated resident #022's secondary mobility device had been broken several weeks ago, which caused the resident to have to remain in their room. They further indicated the primary mobility device had been broken for several months.

By not ensuring staff and others involved in resident #022's care collaborated with each other in order to create a plan to ensure the resident was able to leave their room in order to interact with co-residents and recreation in the home, the resident was placed at risk of becoming depressed and experiencing identified feelings and responsive behaviours.

Sources: Resident #022's progress notes and assessments from an identified period of time; observations of resident #022; interviews with resident #022, RPNs #119 and #131, PT, OT, NM #005 and the DOC.

This order must be complied with by August 19, 2022

COMPLIANCE ORDER CO#008 – INFECTION PREVENTION AND CONTROL

NC#012 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 r. 102 (8)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 102 (8) of O.Reg 246/22.

Specifically, the Licensee must:

1. Provide leadership, monitoring, and supervision from the management team in all home areas and all shifts to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2. Conduct daily hand hygiene audits for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

3. Conduct daily audits of PPE donning/doffing and usage to ensure PPE is being utilized, donned and doffed as required, for the duration of the outbreak. Keep a documented record of the audits completed and make available for Inspectors, upon request.

4. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the education, training and audits completed and make available for Inspectors, upon request.

5. All PPE caddies must be fully stocked and have appropriate PPE items in them.

Grounds

Non-compliance with O. Reg. 246/22 r. 102 (8)

The licensee has failed to ensure that all staff participated in the infection prevention and control program.

Rationale and Summary:

During observations conducted in the home, Inspectors noted the following infection prevention and control practices:

- Hand hygiene was not offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff did not complete hand hygiene between assisting/serving residents during meals and/or nourishment services.

- Open rolls of toilet paper were observed sitting on the back of toilets, countertops and on the floor beside the toilet in several shared bathrooms and spa rooms.

- In multiple resident bathrooms, there were unlabeled urine collection containers and/or unlabeled bed pans sitting on the backs of toilets and/or on the bathroom floors.

- PPE stations outside of multiple resident rooms who required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, masks or disinfectant wipes.

- Staff and visitors were observed exiting the home while still wearing their face shields and/or masks, without cleaning or changing the items upon exiting the home.

- Some Essential Visitors were observed to be in resident bedrooms where contact/droplet precautions were required, without wearing all of the required PPE items.

- Staff members did not maintain physical distancing, such as entering elevators which already had groups of people on them, therefore being unable to maintain the suggested physical spacing between individuals.

-Some staff were observed to be wearing PPE items incorrectly, such as masks sitting under the nose.

- Staff were observed exiting resident rooms which had contact/droplet precautions implemented but did not change their masks and/or clean their eye protection following the provision of resident care.

The observations demonstrated there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the COVID-19 virus.

Sources: Observations conducted; interviews with PSWs, RPNs, RNs, housekeeping and dietary staff, Nursing Managers, IPAC Lead and the Director of Care.

This order must be complied with by August 19, 2022

COMPLIANCE ORDER CO#009 – PERSONAL SUPPORT SERVICES

NC#013 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 r. 41 (1) (a)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with r. 41 (1) (a) of O.Reg 246/22.

Specifically, the Licensee must:

1) Conduct bi-weekly audits of the resident home areas for a minimum period of four weeks. The audits are to include the tub and shower rooms, care trolleys and baskets, to ensure that all personal items are appropriately labelled with the resident's name. Keep a documented record of the audits completed and make available to Inspectors upon request.

Grounds

Non-compliance with O. Reg. 246/22 r. 41 (1) (a)

The licensee failed to ensure that personal items were labelled, as required.

Rationale and Summary:

While conducting observations, Inspector observed multiple personal items in shared resident bathrooms and bedrooms, such as used rolls of deodorant, hair combs and hairbrushes, denture cups, toothbrushes and razors which were not labelled as required with the resident's name.

During separate interviews, PSWs and the Director of Care verified the expectation in the home was for all personal items to be labelled with the resident's name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident's personal item, which could be unsanitary.

Sources: Observations conducted, interviews with PSWs and the Director of Care.

This order must be complied with by August 19, 2022

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.