Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2022	2022_960695_0001	010323-21, 010328-21, 010587-21, 010755-21, 015066-21, 018361-21	Complaint

Licensee/Titulaire de permis

Shalom Village Nursing Home
60 Macklin Street North Hamilton ON L8S 3S1

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

Shalom Village Nursing Home
70 Macklin Street North Hamilton ON L8S 3S1

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

FARAH_ KHAN (695), ADELFA ROBLES (723), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 4- 7, 10-14, 17- 21, 24-28, and 31, 2022, and February 1, 2022.

The following intakes were completed in this complaint inspection:
Log #018361-21 was related to responsive behaviours, Infection prevention and control, and unexplained bruising.
Log #015066-21 was related to personal care and unexplained bruising.

Log # 010755-21 was related to infection prevention and control, sufficient staffing, dining, orientation and training, and leadership.
Log# 010587-21 was related to sufficient staffing, personal care, dining, and leadership.
Log # 010328-21 was related to dining, sufficient staffing, personal care, and training of staff.
Log # 010323-21 was related to sufficient staffing, orientation and training, alleged sexual abuse, written complaints process, call bell system, hiring and recruitment of staff, infection prevention and control, and personal care.

NOTE: A Written Notification and Voluntary Plan of Correction related to O. Reg. 79/10, s. 53(4)(b), O. Reg. 79/10, s. 221(2), O. Reg. 79/10, s. 98 and LTCHA s. 24(1) were identified in a concurrent inspection #2022_960695_0002 (Log # 012823-21 and Log # 008924-21) and issued in this report.

NOTE: A Written Notification and Compliance Order related to LTCHA s. 19 and LTCHA s. 20. (1) were identified in a concurrent inspection #2022_960695_0002 (Log # 008924-21 and Log # 012823-21) and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the former Director of Care (DOC), two Assistant Director of Cares (ADOCs), Director of Human Resource (HR), HR Consultant, HR Coordinator, previous head of HR, the Public Health (PH) Inspector, scheduling coordinator, executive assistant, Environmental Services Manager, recreational therapists, dietary aide, screeners, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and housekeeping staff.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **22 WN(s)**
- **16 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect two residents from abuse by PSW #142.

Ontario Regulation 79/10 defines sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

a) RPN #140 witnessed PSW #142 inappropriately apply an intervention to resident #012.

The Administrator confirmed that this was not the appropriate way to apply the intervention.

Sources: Long-term Care Homes (LTCHs) investigation notes; and interviews with RPN #130, RN #143, the Administrator and the ADOC's.

b) Resident #007 reported to RPN #130 that PSW #142 was inappropriate with them.

Failing to protect resident #012 and #007 from abuse had the potential to cause significant harm.

Sources: LTCHs investigation notes; Critical Incident (CI) report; and interviews with a RPN, RN, the Administrator and the ADOC's. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the long-term care home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's abuse policy directed staff to call the On Call manager to immediately report abuse, assess the resident for injuries and document the incident in the resident's clinical record, and to obtain written statements from all witnesses or their account of the incident. In addition, the home's abuse policy stated that the education provided during orientation and annually would focus on learning through actual clinical situations and clinical examples, and paying particular attention to subtle forms of abuse and neglect.

a) An alleged abuse incident occurred when RPN #140 witnessed PSW #142 inappropriately apply an intervention to resident #12.

The incident was not reported to management until four days after it had occurred, and there was no documentation of the incident or assessments conducted in resident #012's clinical record.

In addition, the home's policy regarding annual and orientation training was not followed as their training did not include learning through actual clinical situations and clinical examples, and did not pay particular attention to subtle forms of abuse and neglect.

When the incident was not immediately reported and there was no documentation of what occurred in their clinical record, it delayed further actions being taken. As a result, PSW #142 was able to return to work and another abuse incident occurred. Not assessing resident #012 after the incident occurred, increased the risk that the resident may have not received the support or referrals they needed.

Sources: LTCH's investigation notes; resident #012's clinical record including progress notes and assessments; the LTCH's abuse policy; interviews with a RPN, ADOC #108, ADOC #109, and the Administrator.

2. An alleged abuse incident occurred when resident #007 reported to RPN #130 that PSW #142 was inappropriate with them.

There was no evidence that the resident was assessed after the incident and there were no written statements or interview notes kept from PSW #142.

When resident #007 was not assessed after the incident, it increased the risk that they may not have received the support or referrals they needed.

Sources: LTCH's investigation notes; CI report; review of resident #007's clinical record including progress notes and assessment; the LTCH's abuse policy; and interviews with nursing staff, the Administrator and ADOC's.

3. PSW #135 and PSW #138, entered resident #013's room to provide care. During the time that care was provided, the resident sustained an injury and both PSWs stated they were unsure how it occurred. Their son alleged that this was neglect.

There were no written statements or documentation of witness accounts obtained from either PSW #135 or PSW #138.

When interviews were not conducted with all witnesses as part of an alleged abuse investigation, the results of the investigation may have been inaccurate, which placed residents at risk for being abused in the future.

As a result of not complying with the home's abuse policy, there was an increase risk of abuse to the residents.

Sources: LTCH's investigation notes; CI report; the internal incident report; resident #013's the progress notes, the LTCH's abuse policy; and interviews with a PSW, RN, and ADOC #109. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that persons who received training in subsection (2) received retraining for the home's policy to promote zero tolerance of abuse and neglect of residents.

The annual training provided to staff online in 2021, including new hires, related to the LTCH's policy to promote zero tolerance of abuse and neglect of residents, was reviewed with human resource (HR) coordinator #146 and the Director of HR. The online policy was last revised August 2014.

The LTCHs Inspector compared the home's current policy to promote zero tolerance of abuse and neglect of residents, with the prevention of abuse policy provided online in the annual training. The version of the policy on Surge online training did not direct staff to assess the resident for injury and provide medical intervention, document the incident in each resident chart, contact the physician and request a full medical examination, contact the police immediately of any alleged, suspected or witnessed abuse that may constitute a criminal offence, or direct the home on the mandatory items required in training.

For two incidents of alleged sexual abuse, there was no documentation in the residents' charts about the incidents, whether the residents were assessed after the incidents, it was not reported to the Director immediately, and the police were not contacted immediately. After one of the incidents the physician was not notified.

The current policy titled, Abuse or Suspected Abuse of a Resident, directed the home to include in the annual and orientation training: training on the power imbalances between staff and residents, and potential situations that could lead to abuse and neglect, and how to avoid those situations. In addition, the policy titled, Abuse and Neglect, directed the home to focus education on learning through clinical situations and clinical examples, paying particular attention to subtle forms of abuse. These items were not included in the current online Surge training.

The ADOC acknowledged that the online version of the abuse policy for new staff and for annual retraining was outdated.

The lack of adequate training may have increased the risk for delays and lack of reaction to alleged abuse situations by staff. As a result, residents were at significantly higher risk of not being protected from abuse by the home.

Sources: Observations of Surge online training for the policy titled, Prevention of Resident Abuse and Neglect; a record review of the training that was completed for PSWs and Nurses; policy titled, Abuse or Suspected Abuse/Neglect of a Resident, reference #: 005010.00 last reviewed December 18, 2018, policy titled, Prevention of Resident Abuse and Neglect, revised August 2014; and Interviews with PSW# 142, PSW #101, RN #143, ADOC #109, the Director of HR and the HR Coordinator. [s. 76. (4)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 215. Police record check

Specifically failed to comply with the following:

s. 215. (8) When a licensee hires a staff member or accepts a volunteer during a pandemic, the following modifications to the requirements of subsection 75 (1) of the Act and of subsections (1) to (5) of this section apply:
1. Before a staff member is hired or a volunteer is accepted by a licensee, the licensee shall, subject to Column 4 of the Table to section 1 of the Schedule to the Police Record Checks Reform Act, 2015, require that the staff member or volunteer provide the licensee with a signed declaration disclosing the following matters with respect to the period since the date of their last police record check under subsection (2) was conducted, or if no such police record check has been conducted, of every occurrence of the following matters:
i. Every offence with which they have been charged under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada) and the outcome of the charge.
ii. Every order of a judge or justice of the peace made against them in respect of an offence under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), including a peace bond, probation order, prohibition order or warrant to arrest.
iii. Every offence of which they have been convicted under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada). O. Reg. 72/20, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that before PSW #142 and PSW #123 were hired, the licensee required the staff members to provide the licensee with a signed declaration disclosing the following with respect to the period since the date the person's last police record check was conducted:

i. Every offence with which they have been charged under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada) and the outcome of the charge.
ii. Every order of a judge or justice of the peace made against them in respect of an offence under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), including a peace bond, probation order, prohibition order or warrant to arrest.
iii. Every offence of which they have been convicted under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada).

A complaint was received expressing concerns related to the onboarding of new staff.

PSW #142, who was hired in 2021, was involved in two incidents of abuse in the home. Upon review of the PSW's human resource (HR) file, there was no police check or declaration of past criminal offences completed upon hire.

PSW #123 started working in the home in 2021. There was no police record check or declaration of past criminal offences in their HR file.

There was no evidence a police check was conducted for PSW #142 and #123.

Sources: Record review of HR file for PSW #142 and #123; and interviews with the Director of HR and HR coordinator. [s. 215. (8) 1.]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure, that as a requirement to keep the home a safe and secure environment, the home followed specific guidelines for the use of N95 masks as set out in Directive #5.

In accordance with the Minister's Directive #5, the licensee was required to ensure that all health care workers providing direct care to or interacting with a suspected, probable (i.e. placed in precautions as high risk contact, in an outbreak zone of the facility or recently transferred from a facility in outbreak) or confirmed cases of COVID-19 wore a fit-tested, seal-checked N95 respirator (or approved equivalent).

a) For the majority of this inspection, the LTCH was in Covid-19 outbreak.

i) Recreational therapist #118 was observed feeding a resident who was on precautions that required staff to wear an N95 respirator. The recreational therapist wore an N95 respirator but informed the inspector they did not know their size.

ii) RPN #148 was observed on an outbreak unit exiting from one resident's room and entering into another resident's room without an N95 respirator. The RPN acknowledged they were not wearing an N95 respirator and should be while on an outbreak unit.

iii) RPN #172 was working on an outbreak unit. They stated they were not wearing the N95 respirator they were fitted to as they were told they could wear a universal size instead.

Upon review of the home's staff list of N95 respirator sizes, recreational therapist #118 and RPN #172 were not wearing the size they were fitted for while working on Covid-19 outbreak units. RN #153 stated they were directed to use the universal mask as it was more readily available in the home.

The ADOC acknowledged that all staff on the outbreak units were expected to wear the N95 respirator they were fitted to.

b) Interviews and observations identified that multiple staff members were working on outbreak units. Each were hired in 2021 and confirmed they had not had mask-fit testing

completed.

Inspector #695 reviewed the list that the home provided of staff who had been mask fit tested. There were more than 80 staff members on the list provided that were either not mask fit tested, their mask fit testing was expired since 2020, or were fitted to a mask that had not been available in the home for an extended period of time.

As per ADOC #109 there had not been anyone in charge of ensuring staff, including new hires, had received mask fit testing in 2021. The ADOC also stated that there was a particular size that the home was unable to obtain for a long period of time.

The policy regarding the use of the N95 mask, directed all staff to be fit tested upon hiring and at minimum once every 2 years thereafter.

Public Health Inspector #107 stated they directed the home to ensure all healthcare workers were wearing fit-tested, seal-checked N95 respirators when on outbreak units.

When staff were not wearing the appropriate fit tested N95 mask, there was an increased risk of staff contracting the infectious agent.

Sources: Observations of staff with residents and on outbreak units; CMOH’s Directive #5, effective December 20, 2021; LTCH's list of staff that were N95 mask fit tested; LTCH's list of residents who contracted Covid-19; LTCH’s policy for use of the N95 mask; CI report; nursing and PSW schedule; and interviews with PSWs, RPNs, a recreational therapist, an RN, a Public Health Inspector, and ADOC #109.

2. The licensee has failed to ensure, that as a requirement to keep the home a safe and secure environment, the home followed specific guidelines for screening of all individuals entering the building set out in Directive #3.

Chief Medical Officer of Health (CMOH)’s Directive #3 required homes to ensure that all individuals were actively screened for symptoms and exposure history for COVID-19 before they were allowed to enter the home, as per the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes.

The COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes directs at a minimum, that all individuals entering the home are actively screened using specific questions. This included reviewing each symptom (five in total) and asking a set

of six questions related to their possible exposure to COVID-19.

LTCH's Inspector #506, #723 and #695 were allowed into the home by PSW #167 in the early morning. Active screening was not completed; the Inspectors were not asked whether they had symptoms related to Covid-19, whether they (or a household member) had traveled outside the country and were required to quarantine, whether they were asked to self isolate by a doctor, health care provider or public health unit, whether they had been in close contact (or lived) with someone with Covid-10 symptoms or who had tested positive for Covid-19, whether they had received a COVID Alert exposure notification on their cell phone, whether they had tested positive on a rapid antigen test or a home-based self-testing kit, or whether they lived with someone who was waiting for Covid-19 test results.

Scheduling coordinator #171 was also allowed into the home by PSW #167 and no active screening was conducted.

The scheduling coordinator stated that they regularly entered the building during the early morning and were not actively screened.

PSW #167 stated they allowed individuals to enter the building when they worked the night shift, including into the long-term care home section, and they do not provide active screening.

ADOC #109 acknowledged that there should have been an active screening process at all times of the day.

When individuals were not actively screened at the entrance, it posed a risk that someone carrying the virus could enter the facility, causing potential risk of harm to residents.

Sources: Observations of entrance screening; CMOH's Directive 3, COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes; and interview with the scheduling coordinator, a PSW, and ADOC #109. [s. 5.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident had the right to be afforded privacy in treatment and in caring for their personal needs, when a sign was posted on their door stating their current medical condition.

Inspector #695 observed a sign on a resident's door stating they had a specific medical condition and reminding individuals entering the room of the precautions they must take.

Posting the resident's condition on their door had potential to result in a breach of their personal health information.

ADOC #108 acknowledged that this was a breach of privacy.

Sources: Observations of a resident's room; progress notes for the resident; and an interview with ADOC #108. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents are afforded privacy in treatment and in caring for their personal needs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care was provided to resident #032 as specified in their plan of care.

There were complaints made to the Director that residents were being dressed and awakened prior to 0430 hours.

Resident #032 was observed in their bed with their street clothes on sleeping.

PSW #160 confirmed that they had dressed the resident prior to 0500 hours.

The plan of care for resident #032 identified under sleep and rest that they preferred to wake up significantly later than 0500hrs.

ADOC #109 confirmed that the plan of care was not followed as the resident was dressed earlier than their preferred time.

There was risk to the resident for being awakened prior to their preference as they may not have had adequate rest.

Sources: resident #032's clinical record; observation; and staff interviews. [s. 6. (7)]

2. The licensee failed to ensure that the care was provided to resident #017 as specified in their plan of care.

The plan of care for resident #017 identified that they were to have a specific intervention applied during the day.

The clinical record for resident #017 included a progress note that the family was concerned that the resident did not have the intervention applied that day.

RN #154 confirmed that the plan of care was not followed as the resident did not have the intervention applied that day.

The risk of the resident not having the intervention applied as ordered could have led to increased medical complications.

Sources: resident #017's clinical record; and interview with RN #154. [s. 6. (7)]

3. The licensee failed to ensure that falls interventions were implemented for resident #034, #009 and #011, as specified in their plan of cares.

a) Resident #034 had a fall and sustained a significant injury. After the fall, a new falls prevention intervention was added to their plan of care.

The resident was observed on two separate occasions without the proper falls intervention in place. RPN #124 acknowledged that the falls intervention was in their plan of care but was not implemented.

Failure to implement the falls prevention intervention could have resulted in increased risk for falls and injury for the resident.

Sources: CI report; observations of resident #034; interviews with PSW, nursing staff; and record review of the resident's plan of care.

b) Resident #044 had a fall and sustained significant injury. The resident's plan of care stated they were to have a specific falls prevention intervention in place, but the falls incident note indicated that it was not in place at the time of their fall.

ADOC #108 acknowledged that the resident should have had the falls prevention intervention in place but did not at the time of the fall.

The falls intervention was not implemented which could have prevented the fall and injury to resident #044.

Sources: CI report; interviews with PSWs, nursing staff, and the ADOC; a record review of resident #044's plan of care, fall incident reports, and progress notes.

c) Resident #011 care plan stated that they required a specific falls intervention to assist with the prevention and management of falls. Resident #011 was observed on two separate occasions without the intervention in place. RPN #119 acknowledged that the resident's plan of care stated they required the intervention.

The resident not having the intervention in place as a falls prevention measure could have resulted in a fall and potential injury to resident #011.

Sources: observations of resident #011; interviews with PSWs, nursing staff; record review of the resident's plan of care. [s. 6. (7)]

4.The licensee has failed to ensure that resident #014 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Resident #014's clinical record indicated that they exhibited certain responsive behaviours for a long period of time. The written plan of care did not include a plan for these behaviours nor any triggers, goals or interventions to prevent these responsive behaviours until two months later, when an incident occurred.

The ADOC confirmed that resident #014's plan of care was not reviewed and revised when the resident's care needs changed related to the newly identified responsive

behaviours.

The risk to the resident by not having their plan of care reviewed and revised when care needs changed, were that staff may not have been aware of the responsive behaviours, triggers or interventions to use when the resident was exhibiting responsive behaviours.

Sources: resident #014's clinical record; and interviews with staff. [s. 6. (10) (b)]

5. The licensee has failed to ensure that the plan of care for resident #024 and #015 was revised when they had changes in their care needs related to oral care.

a). The plan of care for resident #024 noted that the resident needed a specific level of assistance and intervention used for oral care.

PSW #151 confirmed that the resident’s care needs changed and they required a different level of care and intervention to complete oral care.

The ADOC confirmed that the plan of care was not revised with the resident's change in care needs.

Failure to ensure that the plan of care was revised with changes in care needs had the potential to result in unmet care related to oral hygiene of the resident.

Sources: Plan of care for resident #024; and interview with PSW #151 and other staff.

b) The plan of care for resident #015 noted that the resident required a certain level of assistance and intervention for their oral care needs.

PSW #151 confirmed that the intervention specified in the resident plan of care was not what they currently required.

The ADOC confirmed that the plan of care was not revised with the resident's change in care needs.

Failure to ensure that the plan of care was revised with changes in care needs had the potential to result in unmet care related to oral hygiene of the resident.

Sources: Plan of care for resident #015; and interview with PSW #151 and other staff.

[s. 6. (10) (b)]

6. The licensee failed to ensure that resident #009 was reassessed and the plan of care reviewed and revised when the resident care needs changed.

Multiple observations were carried out by Inspector #723 with resident #009 and observed that the resident's care was not provided as specified in their plan of care in relation to the use of the call bell.

The resident stated that the intervention was no longer required due to their medical condition.

PSW #117 and RPN#120 confirmed that the residents care needs had changed and they no longer required the specified intervention related to their call bell.

ADOC#109 stated that all registered staff were expected to reassess, review and revise residents' plans of care if the resident’s care needs change. ADOC #109 confirmed that resident #009’s written plan of care was not reviewed and revised in relation to resident #009's use of the specified intervention.

When the resident's plan of care was not reviewed and revised to accurately reflect their current condition, there was a risk that the wrong interventions would be implemented by the staff.

Sources: Observations of resident #009; resident #009’s written plan of care; and interviews with resident #009, PSW, RPN and ADOC. [723] [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is implemented as specified in the plan; and that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the training and education included in the required falls prevention and management program was complied with for all staff.

O. Reg. 79/10, s. 48(1) requires an interdisciplinary program for falls prevention and management is developed and implemented to reduce the incidence of falls and risk of injury.

O. Reg. 79/10, s. 8. (1)(b), requires that the falls prevention and management program is complied with.

Specifically, staff did not comply with the home's policy for falls prevention and management.

The home's policy for falls prevention and management directed all front line staff to receive education on their role in falls prevention upon hire and with annual mandatory education.

There were complaints received regarding the training of staff. There were three instances where falls prevention interventions were not implemented as per the plan of care; one resident had a fall and significant injury. Registered staff interviewed were unclear about their roles and responsibilities, including who was expected to complete post falls assessments and update the resident's plan of care.

The annual training records were reviewed and multiple RNs had not received annual training on falls prevention and management including RN #153, #126, #125, and #176.

ADOC #109 stated that all registered staff were expected to revise the care plan as needed and ensure the appropriate falls prevention strategies were put in place. They acknowledged that there was no specific training provided to staff on their roles and responsibilities related to falls prevention and management.

When staff were not trained on their role and responsibilities in falls prevention and management, residents may not have had the appropriate falls prevention strategies in place and therefore, increased the risk of resident falls with injuries.

Sources: the LTCH's policy for fall prevention and management; review of the annual online training related to falls prevention and management; LTCH's list of staff that received annual training for falls prevention and management; and interviews with registered staff and ADOC #109. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Falls Prevention and Management program is implemented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when they had reasonable grounds to suspect abuse, they reported it immediately to the Director.

a) Resident #007 alleged abuse when they reported to RPN #130 that PSW #142 was inappropriate with them.

The home substantiated abuse through their investigation.

The Administrator acknowledged that the former DOC was aware of the incident on the date it occurred but reported it to the Director the day after.

Sources: CI report; resident #007's progress notes; and interview with the Administrator

b) An alleged abuse incident occurred when RPN #140 witnessed PSW #142 inappropriately apply an intervention to resident #12.

The Administrator acknowledged that the incident was not reported to the Director after management was informed.

Sources: LTCHs investigation notes; and interview with the Administrator [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that an abuse incident towards a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that interventions related to reassessments for resident #009 completed by registered staff were documented.

RPN #120 documented that there was incident involving resident #009. It was endorsed to the incoming team.

The LTCH's investigation notes indicated that there was no assessment carried out for this resident after the incident.

RPN #120 confirmed that they checked on the resident but forgot to document their assessment.

ADOC #109 confirmed that registered staff were expected to document their assessments. As a result of the lack of documentation, management did not become aware of the incident until almost one month later.

When resident #009's assessments and reassessments were not documented, there was lack of sufficient follow up with the resident that could have led to a similar incident occurring again.

Sources: LTCH's investigation notes for resident #009, progress notes for resident #009; and interviews with RPN #120 and ADOC #109. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written staffing plan that included a back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who provided the nursing coverage required under subsection 8 (3) of the Act, could not come to work.

During the course of the inspection, interviews were held with several staff including the leadership team which stated that they were unaware if the home had a written back up plan for nursing and personal care when staff could not come to work.

An interview with PSW #149 revealed that they were not aware of a staffing back up plan. An interview with RPN #130 revealed the home did not have a policy, procedure or documented back up plan for nursing and personal support staffing. If the home was short staffed and the home was unable to find a replacement, they problem solved.

ADOC #109 confirmed that the home did not have a documented staffing back up plan. If the home was short staffed PSWs were divided based on the home areas Case Mix Index (CMI) and if the home was unable to find a replacement, nursing leadership would come in to work on the unit. ADOC #109 also stated that they would discuss the written staffing back up plan with the home's administrator as this was something that they currently did not have in place.

The staffing plan did not include a written back up plan for nursing and personal care which increased the risk to residents related to possible unsafe patient care during staff shortages.

Sources: Interviews with PSW #149, RPN #130 and ADOC #109. [s. 31. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a written staffing plan that includes a back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who provided the nursing coverage required under subsection 8 (3) of the Act, could not come to work, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #030 and #031, who exhibited altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

a) Resident #030 had exhibited altered skin integrity. A review of the clinical record identified that three weekly skin assessments were not completed in a nine-week period.

b) Resident #031 had exhibited altered skin integrity. A review of the clinical record identified that four weekly wound assessments were not completed in an eight-week period.

ADOC #109 confirmed that weekly wound assessments were not completed for resident #030 and #031.

The risk of not completing weekly wound assessments for resident #030 and #031 was that staff could not evaluate if the wounds were worsening.

Sources: Resident #030 and #031's skin and wound assessments; interviews with ADOC #109 and other staff; and the LTCH's policy for skin and wound management. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #023, who had an individualized toileting routine to promote and manage bowel and bladder continence, had their plan implemented.

Resident #023's plan of care stated they required a specific intervention for promoting bowel and bladder continence.

Resident #023 was observed and the specified intervention was not provided at the indicated time.

PSW #168 acknowledged that the resident was supposed to receive the specified intervention but did not.

When resident #023 did not receive their continence related intervention, it could have potentially resulted in less control over their continence.

Sources: observations of resident #023; interviews with PSW #168 and ADOC#2; and a record review of resident #23's plan of care, tasks, and point of care documentation. [s. 51. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies were developed to respond to resident #013, who was demonstrating responsive behaviours.

According to resident #013's clinical record, they were exhibiting specific responsive behaviours since admission. The care plan did not identify these behaviours, interventions to minimize them, or triggers that could cause them, until after an incident occurred approximately two months later.

An incident occurred where resident #013 was exhibiting responsive behaviours and PSW #135 and PSW #138 continued to provide care to them. During the time that care was provided, the resident sustained an injury and both PSWs stated they were unsure

how it occurred. The plan of care was updated the following day with interventions and triggers for managing the specified responsive behaviours.

The ADOC acknowledged that the resident had been exhibiting these responsive behaviours since admission to the home but strategies and triggers to respond to resident #013's responsive behaviors were not added to their plan of care until after the incident.

Staff did not have proper direction on how to manage residents #013's responsive behaviours when triggers were not identified and strategies were not developed and implemented to respond to the resident's responsive behaviors. As a result, the resident sustained an injury.

2. The licensee has failed to ensure that strategies had been implemented to respond to the resident demonstrating responsive behaviours.

PSW #136 and PSW #137 entered resident #13's room to provide care when the resident was exhibiting responsive behaviours. PSW #137 stated they proceeded with providing care and as a result, the resident sustained an injury.

The care plan stated a specific intervention was to be implemented when the resident displayed these responsive behaviours.

RPN #119, who responded to the incident, acknowledged that staff should have followed the intervention stated in the plan of care for resident #013 but did not.

When the PSWs failed to implement the responsive behavior strategies for resident #013, the resident sustained an injury.

Sources: CI report; LTCH’s investigation notes; the internal incident reports for both incidents; record review of resident #013’s progress notes, POC and care plan; and interviews with PSW #137, RN #119 and ADOC #109. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were offered between meal beverages in the morning.

The MLTC received anonymous complaints regarding several care concerns.

LTCHs Inspector #723 observed that the morning beverage cart was not delivered, no morning in between meal beverage was offered and/or served to the residents on a specific unit in the home.

RN #153 confirmed that the snack cart was not delivered to the unit.

Failure to provide in between meal beverages to residents could have resulted in increased nutritional and hydration risks.

Sources: Nutritional Management Services Limited – Shalom Village – Snack Rotation – Fall/Winter 2021-2022; and interviews with PSW #151, DA #161 and RN #153. [s. 71. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a minimum of, a between-meal beverage in the morning, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #012's substitute decision maker (SDM) was notified within 12 hours upon becoming aware of an alleged abuse incident.

Resident #012 was involved in an abuse incident.

The Administrator acknowledged that the family or SDM was not informed of this incident.

Sources: LTCH's investigation notes; and interview with the Administrator and ADOC #108. [s. 97. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that police were immediately notified when two incidents of alleged abuse occurred

a) An alleged abuse incident occurred when RPN #140 witnessed PSW #142 inappropriately apply an intervention to resident #12.

The Administrator acknowledged that the police were not contacted in regards to this alleged abuse incident.

Sources: LTCH's investigation notes; interviews with the Administrator, ADOC #108, and ADOC #109.

b) An alleged abuse incident occurred when resident #007 reported to RPN #130 that PSW #142 was inappropriate with them.

The home substantiated abuse through their investigation.

The police were not notified until the next day.

When police were not notified immediately of the alleged abuse incidents, there was a delay in their investigation and follow up that could have resulted in more incidents occurring.

Sources: CIS #2775-000008-21; LTCH's investigation notes; interviews with the Administrator, ADOC #108, and ADOC #109. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance To ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that for every complaint a documented record was kept in the home that included: the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made by the complainant.

A review of the progress notes during a six month period, for resident #017 included several concerns from the family regarding the care of the resident.

RPN #120 confirmed that some of the concerns expressed by the family they had felt

were non-issues with information and explanation provided to the family immediately; however, there was also documentation that they felt the family were not satisfied with some of the concerns. The RPN stated these concerns were brought to the attention of the At Home Leaders for further follow-up.

There was no further documentation of the type of action taken to resolve the complaint, the final resolution or any response made to or by the complainant related to the concerns.

A review of the complaints binder did not include any record of the complaint.

ADOC #109 confirmed these types of concerns should have been put on a complaints form and submitted to Management for follow-up.

Failure to maintain a record of complaints as required increased the potential for additional complaints and inconsistent actions to resolve concerns.

Sources: Review of complaints binder and progress notes related to resident #017; and interview with ADOC #109 and other staff. [s. 101. (2)]

2. The licensee failed to ensure that there was a documented record, of complaints received, which was reviewed and analyzed for trends, at least quarterly to be taken into account when determining what improvements were required in the home.

A request was made of the Administrator for the complaints log and the quarterly review and analysis for the past two quarters in 2021.

The Administrator confirmed that they did not complete a quarterly review and analysis for their complaints in 2021.

By not reviewing and analyzing their complaints the home may not identify trends.

Sources: review of the complaints binder; and interview with Administrator. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff received the annual required training on behavioural management.

There were complaints received regarding the training of staff in the home.

There were two incidents of staff inappropriately providing care to a resident with responsive behaviours. In one incident, there was no assessment regarding their behaviours prior to the incident, they were not documented in the residents plan of care and interventions were not developed to ensure staff were aware of how to manage those behaviours.

RN #143 was unsure who was responsible for identifying triggers and interventions when a resident had responsive behaviours. RPN #119 believed it was the responsibility of the RN.

ADOC #109 stated that there had not been anyone in charge of education training in 2021. They acknowledged that the following RNs had not received training on behavioural management in 2021: RN #153, #126, #125, #176 and RN #154.

Without proper training in responsive behaviours, staff may not have the knowledge required to identify behaviours, determine triggers and interventions, update the plan of care and ensure interventions were implemented.

Sources: CI report; LTCH's investigation notes; the internal incident reports for both incidents; LTCH's list of staff who received annual for responsive behaviours management; record review of resident #013's progress notes, POC and care plan; and interviews with PSW #137, RN #119 and ADOC #109. [s. 221. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive the training for behavioural management, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection control program, specifically, that they followed proper Personal Protective Equipment (PPE) wearing protocol.

The home's policy for droplet precautions directed staff to perform hand hygiene before and after seeing the resident, wear gloves when touching contaminated surfaces, and gowns when giving care where clothing may get contaminated.

a) PSW #100 assisted resident #001, who was on specific precautions, with care. The PSW did not wear the required PPE when assisting the resident.

Not wearing appropriate PPE for the resident, there was an increased risk of transmission of the infectious agents.

b) PSW #133 went into resident # 027's room to obtain an item that was on their table. This resident was on precautions. The PSW did not wear the appropriate PPE. The PSW obtained the item and did not perform hand hygiene when exiting the room. They were about to enter another resident's room with that same item in their hand.

Not wearing proper PPE or performing hand hygiene, and touching surfaces in the resident's environment who required certain precautions, there was a possibility of transferring the infectious agent to other surfaces out of the room.

ADOC #109 acknowledged that staff should be wearing the appropriate PPE and performing hand hygiene.

Sources: Observations of resident #001 and #027; LTCH's policy titled for droplet precautions; and interviews with PSW #100 and PSW # 133, and ADOC #109. [s. 229. (4)]

2. The licensee failed to ensure that their hand hygiene program was in place in accordance with the Ontario evidence-based hand hygiene (HH) program, "Just Clean Your Hands" (JCYH) related to residents receiving assistance or encouragement with hand hygiene after meals.

The home's policy for hand hygiene did not direct staff to assist and/or encourage residents to perform hand hygiene after meals.

PSW #100 was observed assisting resident #001 with a meal. The resident ate part of the meal themselves using their hands. The resident was not encouraged or assisted to wash their hands when the meal was completed.

Multiple residents on two units were observed exiting the dining room after meal time without being encouraged or assisted to perform hand hygiene.

According to the JCYH program, staff were required to assist residents to clean their hands after meals.

The failure to have a hand hygiene program in place in accordance with evidence-based practices presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observations of residents during breakfast and lunch; LTCH's policy for hand hygiene; "Just Clean Your Hands," program resources; and interviews with PSW #100, PSW #163, and ADOC #108. [723] [s. 229. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's hand hygiene program is in accordance with evidence based practices, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 235. Records of current staff

Specifically failed to comply with the following:

s. 235. (1) Subject to subsection (2), every licensee of a long-term care home shall ensure that the records of current staff members are kept at the home. O. Reg. 79/10, s. 235 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that records of current staff members were kept at the home.

The MLTC received an anonymous complaint related to training and orientation of new hires.

The home's orientation policy directed staff to complete a checklist as part of their orientation and submit it to their coach.

ADOC #109 revealed that the departmental checklist was used as a reference if and when new hires required additional trainings for the DOC or ADOC to follow up. ADOC #109 confirmed that they had not kept tract of their departmental orientation checklist since 2021 and none of the new hire orientation checklists were available in the home.

Failure of the home to ensure that training and orientation records of current staff were kept in the home, could have increased the risk of unsafe and ineffective care to the residents.

Sources: the homes policy for employee orientation and general orientation; PSW Orientation checklists; Team Leader Orientation checklists; and interviews with RPN #156, RN #155 PSW #101, PSW#123, ADOC#109, Director of HR and HR coordinator. [s. 235. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the records of current staff members are kept at the home, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (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: 3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the meal for resident #008 was provided in a congregate dining setting.

Resident #008 was observed in bed for their meal.

RPN #169 stated they have observed the resident receiving this meal in bed regularly. They acknowledged that the plan of care for resident #008 was to receive their meals in the dining room.

The risk of not taking resident #008 into the dining room for meals, was that they were not able to eat meals in a social setting and receive social stimulation.

Sources: Observations of the resident; plan of care for resident #008; and interviews with PSW #168 and RPN #169. [s. 73. (1) 3.]

Issued on this 4th day of March, 2022

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	FARAH_ KHAN (695), ADELFA ROBLES (723), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2022_960695_0001
Log No. / No de registre :	010323-21, 010328-21, 010587-21, 010755-21, 015066-21, 018361-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 28, 2022
Licensee / Titulaire de permis :	Shalom Village Nursing Home 60 Macklin Street North, Hamilton, ON, L8S-3S1
LTC Home / Foyer de SLD :	Shalom Village Nursing Home 70 Macklin Street North, Hamilton, ON, L8S-3S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael Bastian

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Shalom Village Nursing Home, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee must:
a) Ensure that resident #007 and #012 are protected from abuse.

Grounds / Motifs :

1. 1. The licensee failed to protect two residents from abuse by PSW #142.

Ontario Regulation 79/10 defines sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

a) RPN #140 witnessed PSW #142 inappropriately apply an intervention to resident #012.

The Administrator confirmed that this was not the appropriate way to apply the intervention.

Sources: Long-term Care Homes (LTCHs) investigation notes; and interviews with RPN #130, RN #143, the Administrator and the ADOC's.

b) Resident #007 reported to RPN #130 that PSW #142 was inappropriate with them.

Failing to protect resident #012 and #007 from abuse had the potential to cause significant harm.

Sources: LTCHs investigation notes; Critical Incident (CI) report; and interviews with a RPN, RN, the Administrator and the ADOC's.

An order was made by taking the following factors into account:
Severity: There was potential for significant harm to resident #007 and #012 related to this non-compliance.
Scope: Abuse was identified in two out of three residents reviewed, this demonstrated a pattern of non-compliance.
Compliance History: One Compliance Order (CO), 22 Written Notifications (WN) and 17 Voluntary Plan of Corrections (VPCs) have been issued to the home related to different sub-sections of the legislation in the past 36 months. (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 02, 2022

Ontario

Ministry of Long-Term Care

Order(s) of the Inspector

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

Ministère des Soins de longue durée

Ordre(s) de l’inspecteur

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with s. 20. (1) of the LTCHA.

Specifically, the licensee must:
a) Ensure that all staff comply with the licensee's zero tolerance for abuse policy
b) Once all staff are trained on the LTCH's abuse policy, conduct monthly audits until the order is complied with for alleged, suspected or witnessed staff to resident abuse incidents to ensure the policy is followed. The audit must include, but is not limited to, the following:
i) ensure that the incident of abuse is immediately reported to the Director,
ii) the substitute decision-maker is notified,
iii) the incident and assessments are documented in the resident's clinical record,
iv) written accounts are obtained from all witnesses.
c) Maintain written documentation of the audit tool including the person who conducted the audit, what was reviewed in the audit, date the audit was conducted, the outcome of the audit, and corrective actions taken.
d) Ensure that staff training and retraining includes the items identified in the licensee's zero tolerance for abuse policy.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the long-term care home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's abuse policy directed staff to call the On Call manager to immediately report abuse, assess the resident for injuries and document the incident in the resident's clinical record, and to obtain written statements from all witnesses or their account of the incident. In addition, the home's abuse policy stated that the education provided during orientation and annually would focus on learning through actual clinical situations and clinical examples, and paying particular attention to subtle forms of abuse and neglect.

a) An alleged abuse incident occurred when RPN #140 witnessed PSW #142 inappropriately apply an intervention to resident #12.

The incident was not reported to management until four days after it had occurred, and there was no documentation of the incident or assessments conducted in resident #012's clinical record.

In addition, the home's policy regarding annual and orientation training was not followed as their training did not include learning through actual clinical situations and clinical examples, and did not pay particular attention to subtle forms of abuse and neglect.

When the incident was not immediately reported and there was no documentation of what occurred in their clinical record, it delayed further actions being taken. As a result, PSW #142 was able to return to work and another abuse incident occurred. Not assessing resident #012 after the incident occurred, increased the risk that the resident may have not received the support or referrals they needed.

Sources: LTCH's investigation notes; resident #012's clinical record including progress notes and assessments; the LTCH's abuse policy; interviews with a RPN, ADOC #108, ADOC #109, and the Administrator.

2. An alleged abuse incident occurred when resident #007 reported to RPN #130 that PSW #142 was inappropriate with them.

There was no evidence that the resident was assessed after the incident and there were no written statements or interview notes kept from PSW #142.

When resident #007 was not assessed after the incident, it increased the risk that they may not have received the support or referrals they needed.

Sources: LTCH's investigation notes; CI report; review of resident #007's clinical record including progress notes and assessment; the LTCH's abuse policy; and interviews with nursing staff, the Administrator and ADOC's.

3. PSW #135 and PSW #138, entered resident #013's room to provide care. During the time that care was provided, the resident sustained an injury and both PSWs stated they were unsure how it occurred. Their son alleged that this was neglect.

There were no written statements or documentation of witness accounts obtained from either PSW #135 or PSW #138.

When interviews were not conducted with all witnesses as part of an alleged abuse investigation, the results of the investigation may have been inaccurate, which placed residents at risk for being abused in the future.

As a result of not complying with the home's abuse policy, there was an increase risk of abuse to the residents.

Sources: LTCH's investigation notes; CI report; the internal incident report; resident #013's the progress notes, the LTCH's abuse policy; and interviews with a PSW, RN, and ADOC #109.

An order was made by taking the following factors into account:
Severity: There was potential for significant harm when the abuse policy was not followed by staff; as a result there were two incidents of abuse by the same PSW.
Scope: Three out of three incidents reviewed had concerns identified related to not following their abuse policy. This demonstrated a widespread issue.
Compliance History: One Compliance Order, 22 WNs and 17 VPCs have been issued to the home related to different sub-sections of the legislation in the past 36 months. (695)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Aug 01, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order / Ordre :

The licensee must be compliant with s. 76. (4) of the LTCHA.

Specifically, the licensee must:
a) Ensure that all staff, including new hires, are trained on the most current version of the LTCH's policy to promote zero tolerance of abuse and neglect of residents.
b) Records must be kept of the contents of training, person(s) conducting the training, dates they were provided, and the staff that attended.

Grounds / Motifs :

1. 1. The licensee failed to ensure that persons who received training in subsection (2) received retraining for the home's policy to promote zero tolerance of abuse and neglect of residents.

The annual training provided to staff online in 2021, including new hires, related to the LTCH's policy to promote zero tolerance of abuse and neglect of residents, was reviewed with human resource (HR) coordinator #146 and the Director of HR. The online policy was last revised August 2014.

The LTCHs Inspector compared the home's current policy to promote zero tolerance of abuse and neglect of residents, with the prevention of abuse policy provided online in the annual training. The version of the policy on Surge online training did not direct staff to assess the resident for injury and provide medical intervention, document the incident in each resident chart, contact the physician and request a full medical examination, contact the police immediately of any alleged, suspected or witnessed abuse that may constitute a criminal offence, or

direct the home on the mandatory items required in training.

For two incidents of alleged sexual abuse, there was no documentation in the residents' charts about the incidents, whether the residents were assessed after the incidents, it was not reported to the Director immediately, and the police were not contacted immediately. After one of the incidents the physician was not notified.

The current policy titled, Abuse or Suspected Abuse of a Resident, directed the home to include in the annual and orientation training: training on the power imbalances between staff and residents, and potential situations that could lead to abuse and neglect, and how to avoid those situations. In addition, the policy titled, Abuse and Neglect, directed the home to focus education on learning through clinical situations and clinical examples, paying particular attention to subtle forms of abuse. These items were not included in the current online Surge training.

The ADOC acknowledged that the online version of the abuse policy for new staff and for annual retraining was outdated.

The lack of adequate training may have increased the risk for delays and lack of reaction to alleged abuse situations by staff. As a result, residents were at significantly higher risk of not being protected from abuse by the home.

Sources: Observations of Surge online training for the policy titled, Prevention of Resident Abuse and Neglect; a record review of the training that was completed for PSWs and Nurses; policy titled, Abuse or Suspected Abuse/Neglect of a Resident, reference #: 005010.00 last reviewed December 18, 2018, policy titled, Prevention of Resident Abuse and Neglect, revised August 2014; and Interviews with PSW# 142, PSW #101, RN #143, ADOC #109, the Director of HR and the HR Coordinator.

An order was made by taking the following factors into account:
Severity: Not ensuring staff were trained on all aspects of the home's policy to promote zero tolerance of abuse presented a moderate risk to residents for abuse.
Scope: There was widespread concerns identified, as all staff did not receive

training on the current policy.
Compliance History: One Compliance Order, 22 WNs and 17 VPCs have been issued to the home related to different sub-sections of the legislation in the past 36 months. (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 02, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 215. (8) When a licensee hires a staff member or accepts a volunteer during a pandemic, the following modifications to the requirements of subsection 75 (1) of the Act and of subsections (1) to (5) of this section apply:
1. Before a staff member is hired or a volunteer is accepted by a licensee, the licensee shall, subject to Column 4 of the Table to section 1 of the Schedule to the Police Record Checks Reform Act, 2015, require that the staff member or volunteer provide the licensee with a signed declaration disclosing the following matters with respect to the period since the date of their last police record check under subsection (2) was conducted, or if no such police record check has been conducted, of every occurrence of the following matters:
i. Every offence with which they have been charged under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada) and the outcome of the charge.
ii. Every order of a judge or justice of the peace made against them in respect of an offence under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), including a peace bond, probation order, prohibition order or warrant to arrest.
iii. Every offence of which they have been convicted under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada).
2. After a staff member is hired or a volunteer is accepted, the staff member or volunteer has a continuing obligation to promptly advise the licensee respecting any matter mentioned in subsection (4) each time that,
i. the staff member or volunteer has been made aware that a charge has been laid or an order has been made against them, and
ii. in the case of a charge, the staff member or volunteer has been convicted or a charge is otherwise disposed of. O. Reg. 72/20, s. 3.

Order / Ordre :

The licensee must comply with s. 215(8) of O. Reg. 79/10.

Specifically, the licensee must:
a) Ensure that PSW #123 provides a signed declaration disclosing specified charges and convictions for offences since the date the person's last police record check was conducted, or if no such police record check has been conducted, of all occurrences.
b) Before any staff member is hired by the licensee during the pandemic, the licensee must receive a signed declaration disclosing specified charges and convictions for offences since the date the person's last police record check was conducted, or if no such police record check has been conducted, of all occurrences.
c) Maintain a copy of all signed declarations and police record checks with the date completed in the home.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that before PSW #142 and PSW #123 were hired, the licensee required the staff members to provide the licensee with a signed declaration disclosing the following with respect to the period since the date the person's last police record check was conducted:

i. Every offence with which they have been charged under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada) and the outcome of the charge.
ii. Every order of a judge or justice of the peace made against them in respect of an offence under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), including a peace bond, probation order, prohibition order or warrant to arrest.
iii. Every offence of which they have been convicted under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada).

A complaint was received expressing concerns related to the onboarding of new staff.

PSW #142, who was hired in 2021, was involved in two incidents of abuse in the home. Upon review of the PSW's human resource (HR) file, there was no police check or declaration of past criminal offences completed upon hire.

PSW #123 started working in the home in 2021. There was no police record check or declaration of past criminal offences in their HR file.

There was no evidence a police check was conducted for PSW #142 and #123.

Sources: Record review of HR file for PSW #142 and #123; and interviews with the Director of HR and HR coordinator.

An order was made by taking the following factors into account:
Severity: There was moderate harm as one of the PSWs with no record check or declaration was involved in two sexual abuse incidents.
Scope: There was a pattern of concerns identified, as two out of three new staff did not have their required police record check or declaration.
Compliance History: One Compliance Order, 22 WNs and 17 VPCs have been issued to the home related to different sub-sections of the legislation in the past 36 months. (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must comply with s. 5 of the LTCHA.

Specifically, the licensee must:
a) Ensure all staff are N95 mask fit tested, including new hires, those with expired mask-fit tests, and those that were fitted to a mask that is no longer available in the home.
b) Maintain a record in the home of who conducted the mask fit testing, dates, and staff that attended.
c) Maintain a record in the home for all staff that includes their N95 respirator size, and the expiry date.
d) Staff must wear the N95 respirator they are fit tested for when required as per the most current Directive #5 measures, infection prevention and control (IPAC) best practice guidelines, and/or as per public health direction.
e) Ensure that active screening is provided at all times.

Grounds / Motifs :

1. 1. The licensee has failed to ensure, that as a requirement to keep the home a safe and secure environment, the home followed specific guidelines for the use of N95 masks as set out in Directive #5.

In accordance with the Minister's Directive #5, the licensee was required to ensure that all health care workers providing direct care to or interacting with a suspected, probable (i.e. placed in precautions as high risk contact, in an outbreak zone of the facility or recently transferred from a facility in outbreak) or confirmed cases of COVID-19 wore a fit-tested, seal-checked N95 respirator (or approved equivalent).

a) For the majority of this inspection, the LTCH was in Covid-19 outbreak.

i) Recreational therapist #118 was observed feeding a resident who was on precautions that required staff to wear an N95 respirator. The recreational therapist wore an N95 respirator but informed the inspector they did not know their size.

ii) RPN #148 was observed on an outbreak unit exiting from one resident's room and entering into another resident's room without an N95 respirator. The RPN acknowledged they were not wearing an N95 respirator and should be while on an outbreak unit.

iii) RPN #172 was working on an outbreak unit. They stated they were not wearing the N95 respirator they were fitted to as they were told they could wear a universal size instead.

Upon review of the home's staff list of N95 respirator sizes, recreational therapist #118 and RPN #172 were not wearing the size they were fitted for while working on Covid-19 outbreak units. RN #153 stated they were directed to use the universal mask as it was more readily available in the home.

The ADOC acknowledged that all staff on the outbreak units were expected to wear the N95 respirator they were fitted to.

b) Interviews and observations identified that multiple staff members were working on outbreak units. Each were hired in 2021 and confirmed they had not had mask-fit testing completed.

Inspector #695 reviewed the list that the home provided of staff who had been mask fit tested. There were more than 80 staff members on the list provided that were either not mask fit tested, their mask fit testing was expired since 2020, or were fitted to a mask that had not been available in the home for an extended period of time.

As per ADOC #109 there had not been anyone in charge of ensuring staff, including new hires, had received mask fit testing in 2021. The ADOC also stated that there was a particular size that the home was unable to obtain for a

long period of time.

The policy regarding the use of the N95 mask, directed all staff to be fit tested upon hiring and at minimum once every 2 years thereafter.

Public Health Inspector #107 stated they directed the home to ensure all healthcare workers were wearing fit-tested, seal-checked N95 respirators when on outbreak units.

When staff were not wearing the appropriate fit tested N95 mask, there was an increased risk of staff contracting the infectious agent.

Sources: Observations of staff with residents and on outbreak units; CMOH's Directive #5, effective December 20, 2021; LTCH's list of staff that were N95 mask fit tested; LTCH's list of residents who contracted Covid-19; LTCH's policy for use of the N95 mask; CI report; nursing and PSW schedule; and interviews with PSWs, RPNs, a recreational therapist, an RN, a Public Health Inspector, and ADOC #109.

2. The licensee has failed to ensure, that as a requirement to keep the home a safe and secure environment, the home followed specific guidelines for screening of all individuals entering the building set out in Directive #3.

Chief Medical Officer of Health (CMOH)'s Directive #3 required homes to ensure that all individuals were actively screened for symptoms and exposure history for COVID-19 before they were allowed to enter the home, as per the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes.

The COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes directs at a minimum, that all individuals entering the home are actively screened using specific questions. This included reviewing each symptom (five in total) and asking a set of six questions related to their possible exposure to COVID-19.

LTCH's Inspector #506, #723 and #695 were allowed into the home by PSW #167 in the early morning. Active screening was not completed; the Inspectors were not asked whether they had symptoms related to Covid-19, whether they

(or a household member) had traveled outside the country and were required to quarantine, whether they were asked to self isolate by a doctor, health care provider or public health unit, whether they had been in close contact (or lived) with someone with Covid-10 symptoms or who had tested positive for Covid-19, whether they had received a COVID Alert exposure notification on their cell phone, whether they had tested positive on a rapid antigen test or a home-based self-testing kit, or whether they lived with someone who was waiting for Covid-19 test results.

Scheduling coordinator #171 was also allowed into the home by PSW #167 and no active screening was conducted.

The scheduling coordinator stated that they regularly entered the building during the early morning and were not actively screened.

PSW #167 stated they allowed individuals to enter the building when they worked the night shift, including into the long-term care home section, and they do not provide active screening.

ADOC #109 acknowledged that there should have been an active screening process at all times of the day.

When individuals were not actively screened at the entrance, it posed a risk that someone carrying the virus could enter the facility, causing potential risk of harm to residents.

Sources: Observations of entrance screening; CMOH's Directive 3, COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes; and interview with the scheduling coordinator, a PSW, and ADOC #109.

An order was made by taking the following factors into account:
Severity: There was potential for moderate harm related to the transmission of infection from staff not wearing the appropriate personal protective equipment (PPE).
Scope: Five out of seven staff reviewed were either without proper N95 mask fit testing or not wearing their N95 mask size, this demonstrated widespread non-compliance.

Compliance History: One Compliance Order, 22 WNs and 17 VPCs have been issued to the home related to different sub-sections of the legislation in the past 36 months. (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 27, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

Issued on this 28th day of February, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Farah_ Khan

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