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

Ministère des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

Order of the Director

Under the *Fixing Long-Term Care Act, 2021*, S.O. 2021, c. 39 Sched. 1

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**
Name of Director:	
Order Type:	☒Compliance Order, section 155
Intake Log # of original inspection (if applicable):	Log #017824-21
Original Inspection #:	2022_678577_0001
Licensee:	Corporation of the County of Elgin – 450 Sunset Drive, 3rd Floor, Suite 303, St Thomas ON N5R 5V1
LTC Home:	Terrace Lodge – 475 Talbot Street East, 49462 Talbot Line, Aylmer ON N5H 3A5
Name of Administrator:	Christine Leonard

Background:
Ministry of Long-Term Care (MLTC) Inspector #577 and #721821 conducted a Critical Incident inspection at Terrace Lodge (the Home). The inspectors attended the Home on February 15-18, 2022. The inspectors found that the Licensee, Corporation of the County of Elgin (the Licensee), failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Policy to promote zero tolerance, under the *Long-Term Care Homes Act, 2007* (LTCHA). Pursuant to s. 153(1)(a) of the LTCHA, the inspectors issued the following compliance order (CO #001) for the non-compliance finding: "The licensee must be in compliance with s. 20. (1) of O. Reg. 79/10." The Licensee, through legal counsel, on behalf of the Chief Administrative Officer, submitted a letter dated April 05, 2022, requesting the Director to review CO #001. As a result of the Director's review, the inspector's order was altered and a written notification pursuant to s. 20 (1) LTCHA remains. The Director has determined that the inspector's order is altered and a Director's order will be substituted for the inspector's order.

Order:	

To Corporation of the County of Elgin, you are hereby required to comply with the following order(s) by the date(s) set out below:

Non-Compliance with: *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8 Sched. 19., s. 19

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.

Order: Corporation of the County of Elgin (the licensee) is ordered to:

a) Provide training to all direct care staff on the home's revised policy to promote zero tolerance of abuse and neglect as required by the *Fixing Long-Term Care Act, 2021* with a specific focus on recognizing types of abuse, and the individual obligation to immediately report.

b) Maintain a written record of the training including what training was provided, who received the training, and when it was received.

Grounds:

The licensee failed to protect resident #002 from abuse.

a) Failure to Protect – A Critical Incident System (CIS) report was received by the Director on November 5, 2021, which outlined allegations of abuse by Personal Support Worker (PSW) #111 toward resident #002 which occurred on November 04, 2021. The report alleged that PSW #111 had been physically rough with the resident. Later the same day, PSW #111 was overheard by RPN #109 uttering a threat in a condescending tone.

A review of the home's internal investigation notes by Inspector #577, identified that PSW #111 received discipline for physical and emotional abuse in accordance with the Resident Bill of Rights, due to speaking in a harsh tone without empathy when they had provided care to resident #002 in a rough manner.

During an interview with the Administrator, they confirmed that based on the home's investigation, PSW #111 had been physically and emotionally abusive toward resident #002.

b) Failure to comply with the policy to promote zero tolerance – The home's policy to promote zero tolerance of abuse (#2.11) with a review date of December 2020 described different

examples of abuse including unnecessary roughness, threats, refusing to provide care unless a resident conforms to caregiver requests, threatening or intimidating form of verbal communication of a belittling or degrading nature that is made by anyone other than a resident. The policy gave clear direction to staff when it noted that: “In any case of alleged or suspected abuse the employee witnessing or having knowledge of an incident shall verbally report the abuse immediately to her/his direct supervisor or delegate and provide a written statement upon reporting the alleged abuse…”

During an interview with PSW #110, they reported that PSW #111 had been physically rough towards resident #002. In addition, PSW #111 had used a harsh, stern tone with the resident. PSW #110 acknowledged that they had reported it via email to the Administrator and the Resident Care Manager the following morning and should have reported it immediately.

During an interview with Registered Practical Nurse (RPN) #109, they reported that they overheard PSW #111 abuse resident #002. They acknowledged that they failed to immediately report the incident to their supervisor.

During an interview with the Administrator, they confirmed that RPN #109 and PSW #110 should have reported the allegation of abuse immediately.

c) The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee’s policy under section 20 of the *Long-Term Care Homes Act, 2007* to promote zero tolerance of abuse and neglect of residents.

Inspector #577 conducted a record review of the home's policy "Resident Abuse" and noted the last revision date was December 2020. During an interview with the Administrator, they acknowledged that the last review and revision of the Resident Abuse policy was in December 2020.

In conclusion, the licensee failed to protect resident #002 from abuse when PSW #111 physically and emotionally abused the resident, when PSW #110 witnessed physical abuse and did not report, when RPN #109 heard emotional abuse and did not report, and when the licensee did not conduct an evaluation to determine the effectiveness of the licensee’s policy under section 20 of the *Long-Term Care Homes Act, 2007* to promote zero tolerance of abuse and neglect of residents.

This order must be complied with by:	May 20, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 170 of the *Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39 Sched. 1*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
8th Floor, 438 University Ave.
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.

Issued on this 28th day of April, 2022	
Signature of Director:	Alain Plante
Name of Director:	Alain Plante