

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: January 20, 2025

Inspection Number: 2025-1386-0001

Inspection Type:

Complaint
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Taunton Mills, Whitby

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7-10, 13-15, 2025
The inspection occurred offsite on the following date(s): January 16, 17, 2025

The following intake(s) were inspected:

- Intake: #00128026 - Outbreak of Communicable Disease
- Intake: #00129318 - Allegation of staff to resident abuse or neglect
- Intake: #00131584 - Fall of resident resulting in injury
- Intake: #00135268 - Complaint of improper care of resident by staff

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

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Palliative Care
- Reporting and Complaints

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to allow the resident to participate fully in their plan of care, when the nursing staff did not transfer a resident to the hospital when they requested. The resident was transferred to the hospital three and a half hours later when the physician came to the resident home area. The physician directed staff to transfer the resident to the hospital as they had requested earlier.

Sources: Clinical health records, interview with staff, interview with SDM.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

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

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

section 24, 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.

The licensee failed to ensure their zero tolerance of abuse policy was followed when an allegation of abuse of a resident by staff was reported.

A Critical Incident Report (CIR) was submitted to the Director for an allegation of staff to resident abuse by two staff. The licensee failed to put the two staff members on administrative leave pending review of the allegation, as per their policy.

Sources: a CIR, resident clinical health record, licensee's investigation, and an interview with the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

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.

The licensee failed to ensure that an allegation of abuse of a resident was immediately reported to the Director.

A CIR was submitted to the Director for an allegation of abuse of a resident by two staff members. The allegation was not reported to the Director until the next day.

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Sources: a CIR, resident clinical health record, licensee's investigation, and an interview with the DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

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

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

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

The licensee failed to ensure staff used safe repositioning techniques during care of a resident.

A CIR was submitted to the Director for an allegation of staff to resident abuse. A resident was found to have an injury. A review of the licensee's investigation indicated two staff incorrectly repositioned a resident.

Sources: a CIR, resident clinical health record, licensee's investigation, and an interview with the DOC.

WRITTEN NOTIFICATION: Required programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee failed to comply with the licensee's pain management program when a resident's pain was not reported to a nurse.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the pain management program were complied with.

Specifically, the licensee's pain management policy directed staff to report when a resident has pain. This did not occur when a resident expressed pain to two staff.

Sources: a CIR, resident clinical health record, licensee's investigation, the licensee's pain management program and an interview with the DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure that a resident received immediate treatment and interventions when an injury was reported.

A CIR was submitted to the Director for an allegation of staff to resident abuse of a

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

resident. The injury was reported to a nurse. The resident was not assessed until approximately two to two-and-one-half hours after the report.

Sources: a CIR, resident clinical health record, licensee's investigation, and an interview with the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

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

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 10.1 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee failed to ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR) that shall be easily accessible at both point-of care and in other common and resident areas. Any staff providing direct resident care must have immediate access to ABHR that contains 70-90% alcohol concentration.

Hallways leading to resident rooms were observed to not have any permanent wall mounted ABHR units and no portable ABHR bottles available. Resident rooms were observed to have a wall mounted ABHR unit on the wall by the doorway but not

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

located at the point of care.

Sources: Observations of hallways and rooms in resident home areas, interviews with staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

Duty to protect

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

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

Specifically, the licensee shall, at minimum:

1. The Director of Care (DOC) or a management designate will educate Registered Practical Nurse (RPN) #116, and Registered Nurse (RN) #117 on the requirement for immediate reporting allegations or suspicion of abuse to the Director.
2. The DOC or a management designate will educate Personal Support Worker (PSW) #120 on the pain program, specifically what is required of PSWs if a resident reports or displays signs and symptoms of pain. Include in the education PSW#120 is immediately stop care, make sure the resident is safe and report the signs and symptoms of pain to a nurse.
3. The DOC or a management designate will educate PSW #120 on safe transferring and positioning of residents' techniques.
4. The Assistant General Manager will educate the DOC #108 on the licensee's zero tolerance and prevention of abuse policy specific to actions to take after an allegation or suspicion of abuse, neglect and improper care.
5. All education is to be delivered face to face; records are to be kept including the

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

date, content and who provided the education with staff signatures acknowledging they understand the education.

6. Provide records to Inspectors upon request.

Grounds

The licensee failed to protect a resident from improper care that resulted in harm or a risk of harm to the resident.

A CIR was submitted to the Director, regarding alleged staff to resident abuse of a resident.

The following non-compliance was identified within this report specific to the resident:

- written notification, O. Reg. 246/22, s. 53 (1) 4.
- written notification, O. Reg. 246/22, s. 40
- written notification, FLTCA, 2021, s. 25 (1)
- written notification, O. Reg. 246/22, s. 55 (2) (b) (ii)

By failing to ensure the resident was protected from improper care and neglect when they were identified as requiring assessments, and treatment put the resident at risk of additional injury or exacerbation of an injury and uncontrolled pain.

Sources: a CIR, clinical health records, licensee's investigation, photos and interview with the DOC.

This order must be complied with by February 7, 2025

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

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of \$5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO was issued in IR #2022_673672_0005 on March 21, 2022 under the LTCHA, 2007, s. 19 (1)

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

Ministry of Long-Term Care

Long-Term Care Operations Division

Long-Term Care Inspections Branch

Central East District

33 King Street West, 4th Floor

Oshawa, ON, L1H 1A1

Telephone: (844) 231-5702

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

REVIEW/APPEAL INFORMATION

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

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

The written request for review must include:

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

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

Director

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

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

If service is made by:

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

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

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor

Ministry of Long-Term Care

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

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Toronto, ON, M5S 1S4

Director

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

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