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

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Amended Public Copy/Copie modifiée 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 14, 2020	2019_766500_0032 (A1)	016943-19, 019440-19, 021439-19, 023188-19	Complaint

Licensee/Titulaire de permis

Villa Colombo Seniors Centre (Vaughan) Inc.
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

Villa Colombo Seniors Centre (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

Amended by NITAL SHETH (500) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The order report was amended under compliance order #002. The date to submit the written plan for achieving compliance was changed from January 31 to February 21, 2020.

Issued on this 14th day of February, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by NITAL SHETH (500) - (A1)

Amended 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): December 2, 9, 10, 11, 13, 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection concurrently:

Intakes log #021439-19 related to multiple concerns regarding the resident's care, #016943-19 (CIS# 2969-000042-19) related to improper personal care, #023188-19 (CIS# 32969-000056-19) and #019440-19 (CIS #2969-000049-19) related to duty to protect.

This report includes a non-compliance identified under s.6 (7) and r. 221. (1) for resident #001 during inspection #2019_766500_0031, which was completed concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Corporate Clinical Manager, Director of Care (DOC), Assistant Director of Care (ADOC), Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Reception, Staffing Co-ordinator, Residents, and Family member.

During the course of the inspection, the inspector observed residents' care areas, and reviewed residents' and home records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **2 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. 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 has failed to ensure that the care set out in the plan of care was provided to resident #001 and #003 as specified in the plan.

Ministry of Long-term Care (MLTC) received a complaint having multiple concerns with resident #003’s care. The complainant indicated that they made requests to the home in regard to resident #003's care. The complainant indicated that sometimes staff do not use the right size incontinent product for the resident.

a). A review of the emails and pictures sent by the complainant indicated that SDM’s request was not addressed on many occasions.

Observation conducted by the inspector on an identified day, in resident #003’s room indicated a note posted about the SDM's request.

A review of resident #003’s plan of care indicated staff to address the SDM's requests.

The progress notes indicated the SDM raised multiple concerns about their requests not being addressed by the home.

Interview with Personal Support Worker (PSW) #118, indicated that staff are required to address the SDM's requests as indicated in resident #003's plan of care.

Interview with Registered Practical Nurse (RPN) #120 indicated that resident #007, who was resident #003's room mate was complaining about identified health issues, and therefore, staff were not addressing resident #003's SDM's requests during a particular shift to avoid any conflict. RPN #120 confirmed that during this shift, staff were not following resident #003's plan of care.

b). Observations conducted on two consecutive days indicated that resident #003 was not using a specified wheelchair.

The resident's plan of care indicated the staff to use the specified wheelchair for the resident.

A review of the resident's progress notes indicted that the resident received the specified wheelchair two months prior to the inspection.

A review of progress note indicated that the Occupational Therapist (OT), Physiotherapist (PT) and RPN #120 assessed the resident to try an alternative mobility device. The alternative mobility device was found ineffective due to the resident's health conditions. As a result of the discussion, the specified wheelchair was implemented as a Personal Assistance Service Device (PASD).

Interviews with PSW #118 and RPN #119 indicated that in an identified shift resident #003 was not using the specified wheelchair but using an alternative mobility device. PSW #118 and RPN #119 indicated that it was requested by the family.

Interview with PT indicated that they were not aware about the family requesting the resident to use the alternative mobility device. PT indicated that the staff are required to follow the resident's plan of care and the family request for the resident should have been communicated to the PT.

Interviews with PSW #117, #118, RPN #119, #120, Assistant Director of Care (ADOC), and the Director of Care (DOC) indicated that staff are expected to follow the resident's plan of care.

c). A review of the resident's plan of care and clinical record indicated that the resident was using an identified size brief.

Interview with PSW #118 indicated that sometimes, they do not have the identified size incontinent product available and they use a different size incontinent product for resident #003.

Interview with RN #112 indicated that staff are required to use the appropriate size incontinent product for resident #003 based on their plan of care.

Interview with DOC indicated that staff are required to follow the resident's plan of care for the right size of the incontinent product. [s. 6. (7)]

2. MLTC received a complaint on an identified day, indicating that the home alleged resident #001 was placed at risk during a scheduled visit with the visitor in a specified room and the visitor was now banned for a period of time from visiting resident #001.

A review of Critical Incident System (CIS) report indicated information about an incident related to alleged visitor to resident #001 neglect that resulted in risk of harm to resident #001 during their scheduled visit in the specified room.

A review of resident #001's written plan of care indicated that the resident required specified care at certain time periods due to use of devices.

An interview with PSW #108 indicated that they do not go to assist the resident until the identified visitor calls them.

Interviews with PSW #109 and PSW #110 indicated that usually a registered nursing staff will do specified care for resident #001 during their scheduled visits with the identified visitor.

An interview with Agency RPN #107 indicated that specified care should be completed by staff during the identified visitor's scheduled visits, as the visitor is not the SDM and staff are responsible to implement the plan of care for the

resident.

Interview with RPN #111 indicated that usually the identified visitor calls the registered staff frequently and registered staff attends their requests to address the resident's needs.

Interview with the ADOC and the Administrator confirmed that the resident's plan of care related to use of devices should have been implemented by staff during the scheduled visits from the identified visitor.

This non-compliance was issued as a result of the staff having failed to implement care set out in the resident's plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the following were documented: the provision of the care set out in the plan of care.

MLTC received a complaint on an identified day having multiple concerns with resident #003's care.

A review of resident #003's plan of care indicated that the resident to be provided specified care due to use of devices at certain time intervals.

A review of the Point of Care (POC) record indicated that the documentation for the above mentioned specified care were not available, as the tasks were not set up in the POC for staff to document it.

Interviews with PSW #117, #118, RPN #119, the ADOC and the DOC confirmed that the above documentation should have been completed in POC.

This non-compliance is issued as a result of staff having failed to document the resident's provision of care related to use of PASD. [s. 6. (9) 1.]

4. The licensee has failed to ensure that resident #003 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, or care set out in the plan was no longer necessary.

A review of resident #003's plan of care indicated that the resident required assistance for transferring from two persons with the use of device A.

Interviews with PSW #121, and RPN #120, indicated they were using device A to transfer the resident from their specified wheelchair.

Interview with PT indicated that staff were required to use device B to transfer the resident from the specified wheelchair as transferring the resident using device A can be unsafe for the resident. PT indicated that once the resident received a specified wheelchair, the resident should have been assessed for transfer and the plan of care should be reviewed and revised for staff to use device B.

This non-compliance is issued as a result of the staff having failed to review and revise the care plan for new transferring method. [s. 6. (10) (b)]

Additional Required Actions:

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

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 following is documented: the provision of the care set out in the plan of care.
- the resident is 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 has failed to protect resident #007 from abuse by resident #003's visitor.

For the purposes of the definition of "emotional abuse" in subsection 2 (1) of the "emotional abuse" means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences. O. Reg. 79/10, s. 5.

A review of the CIS report indicated an incident of resident #007's emotional abuse by resident #003's visitor. There was a conflict raised between resident #007 and resident #003's visitor in their shared room. Resident #007 confirmed feeling nervous about the incident, and resident #003's visitor giving trouble to resident #007. The resident was assessed by the Nurse Practitioner and found the resident upset by the incident. Resident #007's family member reported resident #003's visitor being a trigger for resident #007's emotions.

There was another CIS report, submitted by the home about an incident of verbal altercation between resident #003's visitor and resident #007. Resident #003's visitor was found being rude to resident #007.

Interview with resident #007 confirmed that they were upset because of the incidents that happened with resident #003's visitor and feeling nervous about it.

A review of the home's investigation notes and progress note indicated that RPN #119 heard resident #003's visitor saying an inappropriate comment to resident #007.

Interview with the Administrator confirmed that abuse was identified as a result of the both incidents. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: 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 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: abuse of a resident by anyone that resulted in harm or a risk of harm to the resident.

A review of two CIS reports related to visitor to resident emotional abuse and visitor to resident verbal altercation indicated that the both incidents were reported to the Director one day later.

Interviews with the Administrator and the Corporate Clinical Manager confirmed that the above-mentioned incidents should have been submitted immediately by the home. [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 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: abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident #007's mood and behaviour patterns, including, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

MLTC received a complaint on an identified day, about resident #007 constantly exhibiting an identified responsive behaviour to the complainant during their visit to resident #003.

A review of the identified CIS reports indicated two incidents of altercation between resident #007 and resident #003's family member.

A review of resident #007's plan of care did not indicate the resident exhibits the identified responsive behaviour. There was no responsive behaviour identified in the plan of care.

A review of progress notes indicated that resident #007 exhibited the identified responsive behaviour to staff on five identified days.

Interviews with PSW #116, #117, #118, RPN #119, Agency RPN #107 confirmed resident #007 exhibited the identified responsive behaviour towards staff and resident #003's family member.

Interviews with RPN #107, ADOC, and DOC confirmed that behaviour should have been assessed and plan of care should have been developed for resident #007.

This non-compliance is issued as a result of the staff failure to develop a plan of care for resident #007's identified responsive behaviour. [s. 26. (3) 5.]

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 plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #5: 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. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

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 for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training was provided to all staff who provide direct care to residents:

-Continence Care and Bowel Management,
-Pain Management,
-for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs,

A review of the home's training record for the above-mentioned programs did not include agency staff working in the home.

Interview with staffing coordinator indicated that the home is using five staffing agencies.

Interview with the DOC indicated that the home does not have agency staff training record for the above-mentioned programs. [s. 221. (1)]

2. The licensee has failed to 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: subject to paragraph 2, the staff receive annual training in all the areas required under subsection 76 (7) of the Act.

A review of the home's training record for the policy on Zero Tolerance to Resident Abuse and Neglect and Responsive Behaviour program did not include agency staff.

Interview with staffing coordinator indicated that the home is using five staffing agencies.

Interview with the DOC indicated that the home does not have an agency staff training record for the above mentioned areas. [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,
a). for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training is provided to all staff who provide direct care to residents:
-Continence Care and Bowel Management,
-for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs,

b). all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: subject to paragraph 2, the staff receive annual training in all the areas required under subsection 76 (7) of the Act:
- Zero Tolerance to Resident Abuse and Neglect
- Responsive Behaviour program, to be implemented voluntarily.

WN #6: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that continence care and bowel management program must, at a minimum, provide for the following: annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated.

Interviews with the Administrator and the DOC confirmed that the above mentioned was not completed by the home. [s. 51. (1) 5.]

Issued on this 14th day of February, 2020 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by NITAL SHETH (500) - (A1)
Inspection No. / No de l'inspection :	2019_766500_0032 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	016943-19, 019440-19, 021439-19, 023188-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 14, 2020(A1)
Licensee / Titulaire de permis :	Villa Colombo Seniors Centre (Vaughan) Inc. 10443 Highway 27, Kleinburg, VAUGHAN, ON, L0J-1C0
LTC Home / Foyer de SLD :	Villa Colombo Seniors Centre (Vaughan) 10443 Highway 27, Kleinburg, VAUGHAN, ON, L0J-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christine Murad

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 Villa Colombo Seniors Centre (Vaughan) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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. 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).

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA, 2007.
Specifically, the licensee must do the following:
1. Review content of resident #001 and #003's written plan of care with direct care staff including Personal Support Workers (PSWs) and Registered Staff and educate staff on the importance of providing care as specified in the plan.
2. Conduct weekly audits for three months, to ensure that staff are providing care as per the plan of care for resident #001 and #003.
3. Maintain record of requirement #1 including but not limited to who attended the review, who provided the review and the date the review was provided and requirement #2 including but not limited to which staff and which resident was being audited, who completed the audit, the date of the audit and the outcome of the audit/actions taken as a result of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 and #003 as specified in the plan.

Ministry of Long-term Care (MLTC) received a complaint having multiple concerns with resident #003's care. The complainant indicated that they made requests to the home in regard to resident #003's care. The complainant indicated that sometimes staff do not use the right size incontinent product for the resident.

a). A review of the emails and pictures sent by the complainant indicated that SDM's request was not addressed on many occasions.

Observation conducted by the inspector on an identified day, in resident #003's room indicated a note posted about the SDM's request.

A review of resident #003's plan of care indicated staff to address the SDM's requests.

The progress notes indicated the SDM raised multiple concerns about their requests not being addressed by the home.

Interview with Personal Support Worker (PSW) #118, indicated that staff are required to address the SDM's requests as indicated in resident #003's plan of care.

Interview with Registered Practical Nurse (RPN) #120 indicated that resident #007, who was resident #003's room mate was complaining about identified health issues, and therefore, staff were not addressing resident #003's SDM's requests during a particular shift to avoid any conflict. RPN #120 confirmed that during this shift, staff were not following resident #003's plan of care.

b). Observations conducted on two consecutive days indicated that resident #003 was not using a specified wheelchair.

The resident's plan of care indicated the staff to use the specified wheelchair for the resident.

A review of the resident's progress notes indicted that the resident received the specified wheelchair two months prior to the inspection.

A review of progress note indicated that the Occupational Therapist (OT), Physiotherapist (PT) and RPN #120 assessed the resident to try an alternative mobility device. The alternative mobility device was found ineffective due to the resident's health conditions. As a result of the discussion, the specified wheelchair was implemented as a Personal Assistance Service Device (PASD).

Interviews with PSW #118 and RPN #119 indicated that in an identified shift resident #003 was not using the specified wheelchair but using an alternative mobility device. PSW #118 and RPN #119 indicated that it was requested by the family.

Interview with PT indicated that they were not aware about the family requesting the resident to use the alternative mobility device. PT indicated that the staff are required to follow the resident's plan of care and the family request should have been communicated to the PT.

Interviews with PSW #117, #118, RPN #119, #120, Assistant Director of Care (ADOC), and the Director of Care (DOC) indicated that staff are expected to follow the resident's plan of care.

c). A review of the resident's plan of care and clinical record indicated that the resident was using an identified size brief.

Interview with PSW #118 indicated that sometimes, they do not have the identified size incontinent product available and they use a different size incontinent product for resident #003.

Interview with RN #112 indicated that staff are required to use the appropriate size incontinent product for resident #003 based on their plan of care.

Interview with DOC indicated that staff are required to follow the resident's plan of care for the right size of the incontinent product. [s. 6. (7)] (500)

2. MLTC received a complaint on an identified day, indicating that the home alleged resident #001 was placed at risk during a scheduled visit with the visitor in a specified room and the visitor was now banned for a period of time from visiting resident #001.

A review of Critical Incident System (CIS) report indicated information about an incident related to alleged visitor to resident #001 neglect that resulted in risk of harm to resident #001 during their scheduled visit in the specified room.

A review of resident #001's written plan of care indicated that the resident required specified care at certain time periods due to use of devices.

An interview with PSW #108 indicated that they do not go to assist the resident until the identified visitor calls them.

Interviews with PSW #109 and PSW #110 indicated that usually a registered nursing staff will do specified care for resident #001 during their scheduled visits with the identified visitor.

An interview with Agency RPN #107 indicated that specified care should be completed by staff during the identified visitor's scheduled visits, as the visitor is not the SDM and staff are responsible to implement the plan of care for the resident.

Interview with RPN #111 indicated that usually the identified visitor calls the registered staff frequently and registered staff attends their requests to address the resident's needs.

Interview with the ADOC and the Administrator confirmed that the resident's plan of care related to use of devices should have been implemented by staff during the scheduled visits from the identified visitor.

This non-compliance was issued as a result of the staff having failed to implement care set out in the resident's plan of care. [s. 6. (7)]

The severity of this issue is a level 3 (actual risk), the scope was a level 2 (pattern), as it related to two out of three residents reviewed and compliance history was level 3 (previous non-compliance to the same subsection) that included Voluntary Plan of Action (VPC) and Written Notification (WN) issued during Inspection:
#2019_780699_0021, dated October 17, 2019,
#2019_631210_0011, dated July 12, 2019,
#2019_530726_0003, dated June 26, 2019,
#2018_530726_0009, dated January 14, 2019,
#2018_751649_0021, dated December 19, 2018,
#2018_751649_0013, dated June 26, 2018,
#2018_751649_0013, dated August 28, 2018,
#2017_420643_0019, dated November 16, 2017,
#2017_656596_0005, dated June 16, 2017,
#2016_397607_0025, dated December 13, 2016, Compliance Order (CO) and WN issued during inspection: # 2017_644507_0015, dated December 4, 2017. (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 08, 2020

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

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Order # / No d'ordre: 002

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

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 :

(A1)
The licensee must be compliant with s. 19 (1) of the LTCHA, 2007.

The licensee shall prepare, submit and implement a plan to ensure that resident #007 and all residents are protected from abuse from resident #003's visitor. The plan must include, but is not limited, to the following: strategies to protect resident #007 and other residents in the home during resident #003's family visits.

Please submit the written plan for achieving compliance for, inspection #2019_766500_0032 to Nital Sheth, LTC Homes Inspector, MLTC, by email to TorontoSAO.moh@ontario.ca by February 21, 2020.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to protect resident #007 from abuse by resident #003's visitor.

For the purposes of the definition of "emotional abuse" in subsection 2 (1) of the "emotional abuse" means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or

(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences. O. Reg. 79/10, s. 5.

A review of the CIS report indicated an incident of resident #007's emotional abuse by resident #003's visitor. There was a conflict raised between resident #007 and resident #003's visitor in their shared room. Resident #007 confirmed feeling nervous about the incident, and resident #003's visitor giving trouble to resident #007. The resident was assessed by the Nurse Practitioner and found the resident upset by the incident. Resident #007's family member reported resident #003's visitor being a trigger for resident #007's emotions.

There was another CIS report, submitted by the home about an incident of verbal altercation between resident #003's visitor and resident #007. Resident #003's visitor was found being rude to resident #007.

Interview with resident #007 confirmed that they were upset because of the incidents that happened with resident #003's visitor and feeling nervous about it.

A review of the home's investigation notes and progress note indicated that RPN #119 heard resident #003's visitor saying an inappropriate comment to resident #007.

Interview with the Administrator confirmed that abuse was identified as a result of the both incidents. [s. 19. (1)]

The severity of this issue is a level 3 (actual harm), the scope was a level 1 (isolated), as it related to one out of three residents reviewed and compliance history was level 3 as there were previous non-compliance to the same subsection that included Voluntary Plan of Action (VPC) and Written Notification (WN) issued during Inspection:
#2019_780699_0021, dated October 17, 2019,
#2018_524500_0009, dated August 27, 2018,
#2018_642606_0002, dated February 23, 2018,
#2017_656596_0004, dated March 19, 2017,
Compliance Order (CO) and WN issued during inspection:

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

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#2019_530726_0005, dated June 26, 2019
#2017_644507_0015, dated December 4, 2017. (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 08, 2020

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

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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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 14th day of February, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by NITAL SHETH (500) - (A1)

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