Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Jun 2, 2015	2015_380593_0005	S-001122-15, 583-14, 586-14, 584-14, 585-14	Follow up

Licensee/Titulaire de permis

MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED BOARD OF MANAGEMENT
70 Robinson Street Postal Bag 460 LITTLE CURRENT ON P0P 1K0

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

MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED
70 ROBINSON STREET POSTAL BAG 460 LITTLE CURRENT ON P0P 1K0

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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 16 - 19, 2015

Compliance Order relating to S.19. (1) was served under this follow-up inspection, however this was actually inspected under CI inspection #2015_380593_0011. The CO was captured in this report as it is linked to a past due order under the same legislation.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Personal Support Workers (PSW), residents and family members.

The inspector also observed the provision of care and services to residents, observed staff to resident Interactions, observed resident to resident Interactions, observed residents' environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
0 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #003	2014_395151_0009	593

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	Legendé 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Inspector #593 conducted a follow-up inspection with reference to inspection report #2014_395151_0009. The home was required to become compliant with the requirement to provide 24/7 on-duty Registered Nurse (RN) coverage. A compliance date of December 19, 2014, was given. A review of the RN staffing schedules between December 19, 2014, and March 16, 2015, by Inspector #593 found that the 12 hour day shift on December 30, 2014, had no RN coverage. The 12 hour RN dayshift 0700 – 1900h was crossed out as the RN was unable to work their scheduled shift.

During an interview with Inspector #593 March 16, 2015, the Director of Care (DOC) reported that on December 30, 2014, the day shift RN was unable to work. They were unable to staff this shift with an RN from their own staffing pool or from an agency. The night shift RN stayed until 0830h until the DOC arrived who is an RN. The DOC advised that they stayed on site until the night shift RN returned at 1900h for their night shift however during this time, they were working primarily as the DOC and they had not worked a nursing shift in several years.

During an interview with Inspector #593 on March 19, 2015, #s-106 reported that there was currently no RN on duty however, they had an RPN on duty from an agency to cover and the DOC is also an RN, who is available if required.

During an interview with Inspector #593 March 19, 2015, the DOC confirmed that the day shift RN was unable to work. They were unable to staff the shift from their own pool of RNs or from the agency however, they were able to obtain an additional RPN from the agency to help with nursing duties. The DOC also added that the night shift RN stayed until they arrived so that there was always a RN on the premises. It was observed this

day that the DOC was working in the capacity of DOC and not as the on duty RN. Later that day, the DOC advised that their understanding of the 24/7 nursing requirements was that as long as an RN was on the premises, then this requirement was met.

A review of the home's staffing plan by Inspector #593 found that RNs are scheduled to ensure 24/7 RN coverage in the home. However there was no documented contingency plan to ensure coverage if RNs were unable to complete their scheduled shift.

Multiple findings of non-compliance were previously issued in inspection 2014_395151_0009 and 2013_139163_003, a compliance order was issued for each pursuant to LTCHA, 2007 S.O. 2007, c. 8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

On two occasions between December 19, 2014 and March 19, 2015, there was no on-duty RN from approximately 08:30 until 19:00. Although the DOC is an RN and was in the home during these times, they were working in the capacity as DOC and not as the RN on-duty. [s. 8. (3)]

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 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 a resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #593 conducted a follow-up inspection with reference to inspection report #2014_395151_0009. The home was required to ensure that residents with altered skin integrity receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument when clinically indicated and that these residents' wounds are reassessed at least weekly by a member of the Registered Staff. A compliance date of December 19, 2014 was given.

A review of resident #004's plan of care found that the resident had a wound on a particular area of their body and that a weekly wound assessment was to be completed. This was confirmed upon review of the Treatment Administration Record (TAR), which documented a requirement for a weekly wound assessment.

A review of resident #004's health care record found completed and documented weekly wound assessments for six dates since the compliance date of December 19, 2014. Three weekly wound assessments were not completed between January 8, 2015, and February 5, 2015. Two dates, during this time period were signed off in the TAR as being

completed however, there was no corresponding documented wound assessment available.

A review of resident #005's plan of care found that the resident had multiple wounds on a particular area of their body. A physician's order dated in 2014, documented that a wound assessment was to be completed weekly due to the wounds on their body. This was confirmed upon review of the TAR, which documented a requirement for a weekly wound assessment.

A review of resident #005's health care record found that in the TAR, 11 dates were signed as the weekly wound assessment having been completed. There was no corresponding documented wound assessment available for five weeks during this time period of the compliance date and the date of the inspection.

A review of resident #006's plan of care found that the resident had a focus of skin integrity related to a skin condition. Upon review of the TAR, it was documented that a weekly wound assessment was required.

A review of resident #006's health care record found that in the TAR, five dates were signed as the weekly wound assessment having been completed.The dates signed off as complete did not correspond with the dates of the documented wound assessments located in the health care record. Weekly wound assessments were not completed for six weeks during the time period of the compliance date and the date of the inspection.

During an interview with Inspector #593 March 19, 2015, the DOC confirmed that there were missing weekly wound assessments in the health care records corresponding with the dates that were signed off as completed. They also confirmed that the weekly wound assessments would not be located anywhere else within the home.

A review of the home's policy # 03-09 Wound Care Record dated June, 2010 found that the effectiveness of skin or wound treatments will be assessed and evaluated weekly by a member of the registered staff. The registered staff initiating skin care or wound care treatment for a resident is responsible for initiating the wound care record and the form is to be completed weekly.

Multiple findings of non-compliance were previously identified in inspection 2014_395151_0009 and 2012_099188_0040, including a compliance order served December 12, 2014, pursuant to O.Reg. 79/10, r. 50. (2) (b) (iv) Every licensee of a long-

term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Over a period of three months, there were numerous missing weekly wound assessments for three residents within the home. All three residents had skin integrity issues and were documented in the TAR for a weekly wound assessment by a member of the registered staff. Furthermore, two of the residents had physician's orders for weekly wound assessments due to problems with skin integrity. [s. 50. (2) (b) (iv)]

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. 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 residents from abuse by anyone and to ensure that residents are not neglected by the licensee or staff.

A Critical Incident was submitted to the Ministry of Health and Long-Term Care on a particular day in 2015, in relation to reported abuse by a PSW towards several residents in the home. During the home's investigation into the alleged abuse by #s-102, it was identified by resident #001 that #s-109 had previously provided rough care and that they reported this to the previous Administrator. During this investigation, it was also raised by #s-108 that residents #005 and #009 had previously complained about #s-109 and their verbal and emotional abuse toward the two residents. #S-108 said that at the time, they had reported this to the RN on duty, #s-110.

During an interview with Inspector #593 on March 17, 2015, the Administrator and DOC

said that they assumed that the previous Administrator had dealt with the two allegations of abuse brought forward involving #s-109. At this time, they had not taken these concerns further either by investigation or reporting to the MOHLTC.

A review of #s-109's employment file found no record or mention of the two incidents of alleged abuse made against the staff member. After the interview March 17, 2015, the Administrator and DOC were able to locate documentation by the former Administrator regarding the two incidents of abuse allegations toward #s-109 as follows:

Incident One

• A note was left for the Administrator by #s-110:

Please read the attached progress notes. Residents #005 and #009 have raised some concerns about #s-109.
The Administrator added a handwritten note to this:

Met with #s-109 and Union Representative, reviewed contents of these notes with staff member.

The progress notes documented by #s-110 were as follows:

Progress Note
Author: #s-110

PSWs reported to writer this afternoon that resident had raised some concerns to them today about #s-109. Writer in to discuss concerns with resident #005 who reported to writer a few different incidents that have taken place in the past. Resident #005 stated that #s-109 is "always sarcastic and rude" with them.

• Resident #005 states that one night they rang their call bell to ask for a particular medication. #S-109 entered room to respond to the call bell. Resident #005 asked #s-109 if they could ask the nurse for their pill. Resident #005 stated that #s-109 responded in a sarcastic tone "do you want a SUPER pill"?" repeatedly. Resident #005 stated that they told #s-109 that they just wanted their usual PRN medication.
• Resident #005 reported that on another occasion when they told #s-109 that they needed a particular pill, #s-109 replied "rudely" "of course you do, of course you do".
• Resident #005 reported that on a third occasion #s-109 had applied a medicated cream

to a part of their body. Resident #005 requested that it be redone as #s-109 had missed some spots and resident #005 was having a lot of pain. Resident #005 reported that #s-109 continued to tell them that the next time they would be in the tub that their "skin was going to fall off".
• Resident #005 stated that they find #s-109 to be very sarcastic, rude and unprofessional. Resident #005 continued to say that they are happy #s-109 only works nights and is only responsible for "changing my bum" because if they were getting them washed and in and out of bed, they feel #s-109 would hurt them.

Progress Note
Author: #s-110

Resident #009 reported to writer that when they first moved into the home, they were having difficulty with managing their incontinence and staff were working to help them find an incontinent product that worked for them. They stated that one night, they had been incontinent of urine and needed assistance getting changed/washed. They stated that #s-109 was working and when resident #009 told them they had "wet" themself and needed help, #s-109 pointed to the bathroom and stated "there's the bathroom". Resident #009 continued on to say that #s-109 has no bedside manner and that they are "just not a nice person".

Incident Two

• The Administrator spoke with resident #001 regarding the issue. The resident advised that #s-109 was rough when changing them in the morning and would not speak to them. The Administrator advised them not to tolerate this behaviour and to report this kind of behaviour immediately to the on-duty RN. The Administrator told the resident that they would speak to #s-109 about the matter.
• The Administrator spoke with #s-102 who works with #s-109 on night shift. #S-102 had never had any residents complain about #s-109 or noticed the staff member being rough at any time.
• The Administrator spoke with #s-109 on the phone about the alleged abuse. The staff member was informed that a complaint had been made about rough care and that it was considered abuse. Any further complaints would be dealt with as discipline as they have zero tolerance for abuse.

Under O.Reg. 79/10, emotional abuse is defined as “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".

Under O.Reg. 79/10, physical abuse is defined as "the use of physical force by anyone other than a resident that causes physical injury or pain".

A review of the home's policy #OPER-02-02-04 Resident Abuse- Staff to Resident, dated November 2013, found that the home has a zero tolerance of abuse toward a resident and that abuse includes financial abuse, sexual abuse, physical abuse, emotional abuse and verbal abuse. Furthermore, resident abuse will result in termination and upon notification of suspected or witnessed abuse, the Administrator or Director of Care are to: 1. Advise the employee that there has been a report of suspected or witnessed abuse toward a resident and, 2. Immediately remove the employee from the work schedule, with pay, pending investigation.

Regarding the two incidents occurring, a comprehensive investigation was not completed or documented. After the accused staff member was made aware of the allegations, there was no discipline issued and the home allowed the staff member to continue to provide care to residents in the home including the residents who initially made the abuse allegations.

During an interview with Inspector #593 on March 18, 2015, #s-108 advised that approximately a year previously, residents #005 and #009 made a complaint to them about #s-109 and their inappropriate behaviour when providing care. #S-108 said that they reported the allegations to the RN on duty who took the allegations to the Administrator. #S-108 confirmed that they were never approached by the home to discuss the allegations further.

During an interview with Inspector #593 on March 18, 2015, resident #005 advised that they made a complaint about #s-109 to another staff member in the home, the staff member advised that they would report the complaint to the Administrator. They further added that the Administrator did not speak with them about the complaint nor did they contact their POA about the matter.

During an interview with Inspector #593 on March 18, 2015, resident #001 advised that previously #s-109 was always rough with providing care and was rude when speaking with them. They further advised that they informed the on-duty RN about this who informed the Administrator. Resident #001's SDM was present at the time of this

interview and they told the inspector that they were never informed about this by anyone at the home and that this is the first they were hearing about the incident.

During an interview with Inspector #593 on March 19, 2015, the DOC advised that regarding the allegations of abuse by #s-109 towards residents in the home, they have now submitted a CI and they are beginning an investigation. The DOC and the Administrator were concerned with the allegations and the DOC acknowledged that there were issues with the investigation previously undertaken by the former Administrator.

Multiple findings of non-compliance were previously identified in inspections 2014_395151_0009 and 2013_139163_0017, a compliance order was issued December 12, 2014 and June 14, 2013 pursuant to 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.

The licensee was aware of allegations of emotional and physical abuse by #s-109 towards three residents in the home on numerous occasions. This was confirmed by resident and staff interviews and documented progress notes. The response by the licensee did not include a thorough and documented investigation, notification of POAs, compliance with the home's policy or disciplinary action towards the accused staff member. Furthermore, the home allowed #s-109 to continue to work in the home directly providing care to residents without undertaking a thorough investigation. The licensee has failed to protect residents from abuse by a staff member in the home. [s. 19. (1)]

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. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and the resident's substitute decision-maker (SDM), are notified of the results of the investigation, immediately upon completion of the investigation.

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in 2015, in relation to reported abuse by a PSW towards several residents in the home. During the home's investigation into the alleged abuse by #s-102, it was identified by resident #001 that #s-109 had previously provided rough care and that they reported this to the previous Administrator. During this investigation, it was also raised by #s-108 that residents #005 and #009 had previously complained about #s-109 and their verbal and emotional abuse toward the two residents. #S-108 said that at the time, they had reported this to the RN on duty, #s-110.

During an interview with Inspector #593 on March 17, 2015, the Administrator and DOC said that they assumed that the previous Administrator had dealt with the two allegations of abuse brought forward involving #s-109. At this time, they had not taken these concerns further either by investigation or reporting to the MOHLTC.

A review of #s-109's employment file found no record or mention of the two incidents of alleged abuse made against the staff member however after the previous interview; the Administrator and DOC were able to locate documentation by the former Administrator regarding the two incidents of abuse allegations toward #s-109. There was no mention in these documents of the Administrator contacting the resident's SDM with the results of the home's investigation into the abuse allegations.

A review of the home's policy #OPER-02-02-04 Resident Abuse- Staff to Resident, dated November 2013, found that the Administrator or DOC are to promptly notify the resident and their SDM of the results of the investigation into abuse or alleged abuse toward a resident in the home.

During an interview with Inspector #593 on March 18, 2015, resident #005 advised that they made a complaint about #s-109 to another staff member in the home, the staff member advised that they would report the complaint to the Administrator. They further added that the Administrator did not speak with them about the complaint nor did they contact their POA about the matter.

During an interview with Inspector #593 on March 18, 2015, resident #001 advised that previously #s-109 was always rough with providing care and was rude when speaking with them. They further advised that they informed the on-duty RN about this who informed the Administrator. Resident #001's SDM was present at the time of this interview and they told the inspector that they were never informed about this by anyone at the home and that this is the first they were hearing about the incident.

The licensee was aware of allegations of abuse by #s-109 towards three residents in the home. The response by the home did not include a thorough and documented investigation including notification of the resident and resident's SDM upon completion of the investigation with the results of the investigation. [s. 97. (2)]

Issued on this 30th day of June, 2015

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

Original report signed by the inspector.

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN CHAMBERLIN (593)
Inspection No. / No de l'inspection :	2015_380593_0005
Log No. / Registre no:	S-001122-15, 583-14, 586-14, 584-14, 585-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 2, 2015
Licensee / Titulaire de permis :	MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED BOARD OF MANAGEMENT 70 Robinson Street, Postal Bag 460, LITTLE CURRENT, ON, P0P-1K0
LTC Home / Foyer de SLD :	MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED 70 ROBINSON STREET, POSTAL BAG 460, LITTLE CURRENT, ON, P0P-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CAROL MCIIVEEN

To MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED BOARD OF MANAGEMENT, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_395151_0009, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under s.8 (3) of the LTCHA. This plan is to include:

• Detailed steps the licensee will take to ensure that at least one Registered Nurse, who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.
• The home's contingency plan for ensuring 24/7 Registered Nursing coverage in the home, should a regular Registered Nursing staff member be unavailable for their regular shift as the on-duty Registered Nurse.
• The licensee's plan should they decide to incorporate the Director of Care (DOC) into the regular nursing team, ensuring that if and when the DOC is the Registered Nurse on-duty, they are not working in the capacity of DOC and their regular DOC hours as required in the regulations (O. Reg. 79/10, s. 213 (1)) are not impacted as a result.

This plan is to be submitted to Gillian Chamberlin, Long-Term Care Homes Inspector. Ministry of Health and Long-Term Care, gillian.chamberlin@ontario.ca by June 15, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of

the home is on duty and present in the home at all times.

Inspector #593 conducted a follow-up inspection with reference to inspection report #2014_395151_0009. The home was required to become compliant with the requirement to provide 24/7 on-duty Registered Nurse (RN) coverage. A compliance date of December 19, 2014, was given. A review of the RN staffing schedules between December 19, 2014, and March 16, 2015, by Inspector #593 found that the 12 hour day shift on December 30, 2014, had no RN coverage. The 12 hour RN dayshift 0700 – 1900h was crossed out as the RN was unable to work their scheduled shift.

During an interview with Inspector #593 March 16, 2015, the Director of Care (DOC) reported that on December 30, 2014, the day shift RN was unable to work. They were unable to staff this shift with an RN from their own staffing pool or from an agency. The night shift RN stayed until 0830h until the DOC arrived who is an RN. The DOC advised that they stayed on site until the night shift RN returned at 1900h for their night shift however during this time, they were working primarily as the DOC and they had not worked a nursing shift in several years.

During an interview with Inspector #593 on March 19, 2015, #s-106 reported that there was currently no RN on duty however, they had an RPN on duty from an agency to cover and the DOC is also an RN, who is available if required.

During an interview with Inspector #593 March 19, 2015, the DOC confirmed that the day shift RN was unable to work. They were unable to staff the shift from their own pool of RNs or from the agency however, they were able to obtain an additional RPN from the agency to help with nursing duties. The DOC also added that the night shift RN stayed until they arrived so that there was always a RN on the premises. It was observed this day that the DOC was working in the capacity of DOC and not as the on duty RN. Later that day, the DOC advised that their understanding of the 24/7 nursing requirements was that as long as an RN was on the premises, then this requirement was met.

A review of the home's staffing plan by Inspector #593 found that RNs are scheduled to ensure 24/7 RN coverage in the home. However there was no documented contingency plan to ensure coverage if RNs were unable to complete their scheduled shift.

Multiple findings of non-compliance were previously issued in inspection 2014_395151_0009 and 2013_139163_003, a compliance order was issued for each pursuant to LTCHA, 2007 S.O. 2007, c. 8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

On two occasions between December 19, 2014 and March 19, 2015, there was no on-duty RN from approximately 08:30 until 19:00. Although the DOC is an RN and was in the home during these times, they were working in the capacity as DOC and not as the RN on-duty. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 07, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_395151_0009, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee is hereby ordered to ensure that residents exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, receive 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 and that, when clinically indicated, these residents' wounds are reassessed at least weekly by a member of the registered staff and that these assessments are documented correctly and consistently as per the home's policy.

Furthermore, the licensee is hereby ordered to comply with Policy # 03-09 Wound Care Record (dated June, 2010) specifically to the following sections but not limited to only them:

Policy- The effectiveness of skin or wound treatments will be assessed and evaluated weekly by a member of the registered staff.

Procedures:
1. The registered staff initiating skin or wound care treatment for a resident is responsible for initiating the Wound Care Record.
4. The form is to be completed weekly using the legend on the form to document the wound status and to assess and track wound healing. All registered staff are responsible for checking to confirm that no more than 7 days has elapsed from when the last wound assessment was completed and recorded on the Wound Care Record. The day of the week for wound care assessment/reassessment is to be indicated at the top of the form.

Grounds / Motifs :

1. The licensee has failed 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.

Inspector #593 conducted a follow-up inspection with reference to inspection report #2014_395151_0009. The home was required to ensure that residents with altered skin integrity receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument when clinically indicated and that these residents' wounds are reassessed at least weekly by a member of the Registered Staff. A compliance date of December 19, 2014 was given.

A review of resident #004's plan of care found that the resident had a wound on a particular area of their body and that a weekly wound assessment was to be completed. This was confirmed upon review of the Treatment Administration Record (TAR), which documented a requirement for a weekly wound assessment.

A review of resident #004's health care record found completed and documented weekly wound assessments for six dates since the compliance date of December 19, 2014. Three weekly wound assessments were not completed between January 8, 2015, and February 5, 2015. Two dates, during this time period were signed off in the TAR as being completed however, there was no corresponding documented wound assessment available.

A review of resident #005's plan of care found that the resident had multiple wounds on a particular area of their body. A physician's order dated in 2014, documented that a wound assessment was to be completed weekly due to the wounds on their body. This was confirmed upon review of the TAR, which documented a requirement for a weekly wound assessment.

A review of resident #005's health care record found that in the TAR, 11 dates were signed as the weekly wound assessment having been completed. There was no corresponding documented wound assessment available for five weeks during this time period of the compliance date and the date of the inspection.

A review of resident #006's plan of care found that the resident had a focus of skin integrity related to a skin condition. Upon review of the TAR, it was documented that a weekly wound assessment was required.

A review of resident #006's health care record found that in the TAR, five dates were signed as the weekly wound assessment having been completed.The dates signed off as complete did not correspond with the dates of the documented wound assessments located in the health care record. Weekly wound assessments were not completed for six weeks during the time period of the compliance date and the date of the inspection.

During an interview with Inspector #593 March 19, 2015, the DOC confirmed that there were missing weekly wound assessments in the health care records corresponding with the dates that were signed off as completed. They also confirmed that the weekly wound assessments would not be located anywhere

else within the home.

A review of the home's policy # 03-09 Wound Care Record dated June, 2010 found that the effectiveness of skin or wound treatments will be assessed and evaluated weekly by a member of the registered staff. The registered staff initiating skin care or wound care treatment for a resident is responsible for initiating the wound care record and the form is to be completed weekly.

Multiple findings of non-compliance were previously identified in inspection 2014_395151_0009 and 2012_099188_0040, including a compliance order served December 12, 2014, pursuant to O.Reg. 79/10, r. 50. (2) (b) (iv) Every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Over a period of three months, there were numerous missing weekly wound assessments for three residents within the home. All three residents had skin integrity issues and were documented in the TAR for a weekly wound assessment by a member of the registered staff. Furthermore, two of the residents had physician's orders for weekly wound assessments due to problems with skin integrity. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_395151_0009, CO #002;

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 is required to prepare, submit and implement a plan for achieving compliance under s.19 (1) of the LTCHA. This plan is to include:

1. Strategies to be taken to ensure that all staff report allegations of abuse immediately according to the licensee's policy related to staff to resident abuse.
2. Details of the steps to be taken to ensure that all reported allegations of abuse are immediately and thoroughly investigated, documented and that residents in the home are protected from abuse during the investigation.

Furthermore, the licensee is hereby ordered to comply with Policy # OPER-02-02-04 Resident Abuse
– Staff to Resident (dated November, 2013) specifically to the following sections but not limited to only them:

Responding / Reporting – Suspected or Witnessed Abuse

All Staff
3. Immediately report any suspected or witnessed abuse to the Administrator, Director of Care or their designate and to the MOHLTC Director through the Critical Incident Reporting System / after-hours pager.

Upon Notification
Administrator / Director of Care / Designate
4. a) and b) Notification of the resident's substitute decision-maker (SDM) / power of attorney (POA)

5. Initiate an internal investigation
6. Document pertinent details of the investigation, actions taken during the investigation and any actions taken as a result of the outcome of the investigation
7. Promptly notify the resident and their SDM / POA, of the investigation results

Actions to be taken against the perpetrator

Administrator / Director of Care
2. Immediately remove the employee from the work schedule, pending investigation

This plan is to be submitted to Gillian Chamberlin, Long-Term Care Homes Inspector. Ministry of Health and Long-Term Care, gillian.chamberlin@ontario.ca by June 15, 2015.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone and to ensure that residents are not neglected by the licensee or staff.

A Critical Incident was submitted to the Ministry of Health and Long-Term Care on a particular day in 2015, in relation to reported abuse by a PSW towards several residents in the home. During the home's investigation into the alleged abuse by #s-102, it was identified by resident #001 that #s-109 had previously provided rough care and that they reported this to the previous Administrator. During this investigation, it was also raised by #s-108 that residents #005 and #009 had previously complained about #s-109 and their verbal and emotional abuse toward the two residents. #S-108 said that at the time, they had reported this to the RN on duty, #s-110.

During an interview with Inspector #593 on March 17, 2015, the Administrator and DOC said that they assumed that the previous Administrator had dealt with the two allegations of abuse brought forward involving #s-109. At this time, they had not taken these concerns further either by investigation or reporting to the MOHLTC.

A review of #s-109's employment file found no record or mention of the two incidents of alleged abuse made against the staff member. After the interview March 17, 2015, the Administrator and DOC were able to locate documentation

by the former Administrator regarding the two incidents of abuse allegations toward #s-109 as follows:

Incident One

• A note was left for the Administrator by #s-110:

Please read the attached progress notes. Residents #005 and #009 have raised some concerns about #s-109.
The Administrator added a handwritten note to this:

Met with #s-109 and Union Representative, reviewed contents of these notes with staff member.

The progress notes documented by #s-110 were as follows:

Progress Note
Author: #s-110

PSWs reported to writer this afternoon that resident had raised some concerns to them today about #s-109. Writer in to discuss concerns with resident #005 who reported to writer a few different incidents that have taken place in the past. Resident #005 stated that #s-109 is "always sarcastic and rude" with them.

• Resident #005 states that one night they rang their call bell to ask for a particular medication. #S-109 entered room to respond to the call bell. Resident #005 asked #s-109 if they could ask the nurse for their pill. Resident #005 stated that #s-109 responded in a sarcastic tone "do you want a SUPER pill"?" repeatedly. Resident #005 stated that they told #s-109 that they just wanted their usual PRN medication.
• Resident #005 reported that on another occasion when they told #s-109 that they needed a particular pill, #s-109 replied "rudely" "of course you do, of course you do".
• Resident #005 reported that on a third occasion #s-109 had applied a medicated cream to a part of their body. Resident #005 requested that it be redone as #s-109 had missed some spots and resident #005 was having a lot of pain. Resident #005 reported that #s-109 continued to tell them that the next time they would be in the tub that their "skin was going to fall off".
• Resident #005 stated that they find #s-109 to be very sarcastic, rude and

unprofessional. Resident #005 continued to say that they are happy #s-109 only works nights and is only responsible for "changing my bum" because if they were getting them washed and in and out of bed, they feel #s-109 would hurt them.

Progress Note
Author: #s-110

Resident #009 reported to writer that when they first moved into the home, they were having difficulty with managing their incontinence and staff were working to help them find an incontinent product that worked for them. They stated that one night, they had been incontinent of urine and needed assistance getting changed/washed. They stated that #s-109 was working and when resident #009 told them they had "wet" themself and needed help, #s-109 pointed to the bathroom and stated "there's the bathroom". Resident #009 continued on to say that #s-109 has no bedside manner and that they are "just not a nice person".

Incident Two

- The Administrator spoke with resident #001 regarding the issue. The resident advised that #s-109 was rough when changing them in the morning and would not speak to them. The Administrator advised them not to tolerate this behaviour and to report this kind of behaviour immediately to the on-duty RN. The Administrator told the resident that they would speak to #s-109 about the matter.
- The Administrator spoke with #s-102 who works with #s-109 on night shift. #S-102 had never had any residents complain about #s-109 or noticed the staff member being rough at any time.
- The Administrator spoke with #s-109 on the phone about the alleged abuse. The staff member was informed that a complaint had been made about rough care and that it was considered abuse. Any further complaints would be dealt with as discipline as they have zero tolerance for abuse.

Under O.Reg. 79/10, emotional abuse is defined as “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”.

Under O.Reg. 79/10, physical abuse is defined as “the use of physical force by anyone other than a resident that causes physical injury or pain”.

A review of the home's policy #OPER-02-02-04 Resident Abuse- Staff to Resident, dated November 2013, found that the home has a zero tolerance of abuse toward a resident and that abuse includes financial abuse, sexual abuse, physical abuse, emotional abuse and verbal abuse. Furthermore, resident abuse will result in termination and upon notification of suspected or witnessed abuse, the Administrator or Director of Care are to: 1. Advise the employee that there has been a report of suspected or witnessed abuse toward a resident and, 2. Immediately remove the employee from the work schedule, with pay, pending investigation.

Regarding the two incidents occurring, a comprehensive investigation was not completed or documented. After the accused staff member was made aware of the allegations, there was no discipline issued and the home allowed the staff member to continue to provide care to residents in the home including the residents who initially made the abuse allegations.

During an interview with Inspector #593 on March 18, 2015, #s-108 advised that approximately a year previously, residents #005 and #009 made a complaint to them about #s-109 and their inappropriate behaviour when providing care. #S-108 said that they reported the allegations to the RN on duty who took the allegations to the Administrator. #S-108 confirmed that they were never approached by the home to discuss the allegations further.

During an interview with Inspector #593 on March 18, 2015, resident #005 advised that they made a complaint about #s-109 to another staff member in the home, the staff member advised that they would report the complaint to the Administrator. They further added that the Administrator did not speak with them about the complaint nor did they contact their POA about the matter.

During an interview with Inspector #593 on March 18, 2015, resident #001 advised that previously #s-109 was always rough with providing care and was rude when speaking with them. They further advised that they informed the on-duty RN about this who informed the Administrator. Resident #001's SDM was present at the time of this interview and they told the inspector that they were never informed about this by anyone at the home and that this is the first they were hearing about the incident.

During an interview with Inspector #593 on March 19, 2015, the DOC advised

that regarding the allegations of abuse by #s-109 towards residents in the home, they have now submitted a CI and they are beginning an investigation. The DOC and the Administrator were concerned with the allegations and the DOC acknowledged that there were issues with the investigation previously undertaken by the former Administrator.

Multiple findings of non-compliance were previously identified in inspections 2014_395151_0009 and 2013_139163_0017, a compliance order was issued December 12, 2014 and June 14, 2013 pursuant to 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.

The licensee was aware of allegations of emotional and physical abuse by #s-109 towards three residents in the home on numerous occasions. This was confirmed by resident and staff interviews and documented progress notes. The response by the licensee did not include a thorough and documented investigation, notification of POAs, compliance with the home's policy or disciplinary action towards the accused staff member. Furthermore, the home allowed #s-109 to continue to work in the home directly providing care to residents without undertaking a thorough investigation. The licensee has failed to protect residents from abuse by a staff member in the home. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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