Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 19, 2018	2018_624196_0027	026356-18, 026605-18	Complaint

Licensee/Titulaire de permis

Board of Management of the District of Kenora
1220 Valley Drive KENORA ON P9N 2W7

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

Northwood Lodge
51 Highway 105 P.O. Box 420 RED LAKE ON P0V 2M0

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

LAUREN TENHUNEN (196)

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): November 5 - 8, 2018.

The following intake inspected upon during this Complaint inspection included:
- One regarding alleged staff to resident abuse and neglect.

The following Critical Incident System intake related to the same issue was inspected during this Complaint inspection:
- One regarding alleged staff to resident abuse.

Follow Up inspection #2018_624196_0028 and Critical Incident System (CIS) inspection #2018_624196_0029 were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurses (RPNs), Resident Assessment Instrument (RAI) Coordinator, Personal Support Workers (PSWs) and Residents.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed a CIS investigation file, employee training records, the submitted CIS report, the submitted complaint report, employee records and the licensee's policy on zero tolerance of abuse and neglect of residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
2 VPC(s)
1 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

The licensee submitted a Critical Incident System (CIS) report on a specific date in 2018, upon receiving a complaint on that same day, from a staff member to the Administrator. The report stated that PSW #108 had witnessed PSW #104 being abusive towards a resident but was unable to provide specific dates or times that the incidents had occurred. The report further identified that the incidents happened over a particular time period.

Inspector #196 reviewed the home's investigation information related to the CIS report of alleged abuse of residents. Through the Administrator's investigation, there were additional incidents of alleged resident abuse identified.

There was information from PSW #107 which identified incidents in which PSW #104 had allegedly abused three residents.

Further CIS investigation notes included statements from PSW #103, #105 and #106 that identified incidents in which PSW #104 had displayed alleged abusive behaviour towards residents.

During an interview, PSW #103 reported to the Inspector that they hadn’t reported anything.

During an interview, PSW #107 reported to the Inspector that they hadn't reported for a specific reason.

During an interview, PSW #108 reported to the Inspector that they hadn’t come forward right away.

The licensee’s policy titled "Zero Tolerance of Abuse and/or Neglect - ADM450", last revised September 2014, was reviewed by the Inspector. The policy read "Reporting an Incident, All staff, volunteers, contractors and affiliated personnel are required: to immediately report to the appropriate supervisor in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect. The supervisor, in turn, will report the witnessed or alleged incident of abuse or neglect to the Director of Care and

/or Administrator."

During an interview, the Administrator confirmed to the Inspector that PSW #103, #105, #106, #107 and #108, had not followed the home's policy on "Zero Tolerance of Abuse and/or Neglect - ADM 450", specifically that incidents of alleged abuse were not immediately reported to an appropriate supervisor. [s. 20. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee submitted a Critical Incident System (CIS) report on a specific date in 2018, upon receiving a complaint on that same day, from a staff member to the Administrator. The report stated that PSW #108 had witnessed PSW #104 being abusive towards a resident but was unable to provide specific dates or times that the incidents had occurred. The report further identified that the incident happened over a particular time period.

Inspector #196 reviewed the home's investigation information related to the CIS report of alleged abuse of residents. Through the Administrator's investigation, there were additional incidents of alleged resident abuse identified.

Inspector #196 reviewed the licensee's submitted CIS reports and failed to identify any reports regarding these alleged staff to resident abuse incidents.

During an interview, the Administrator confirmed to the Inspector that the the alleged incidents of abuse/neglect of residents that were reported during the home's investigation into the original CIS of alleged abuse, were not reported to the Director. [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 that ensures that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident’s substitute decision-maker, if any, and any other person specified by the resident, (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee submitted a Critical Incident System (CIS) report on on a specific date in 2018, upon receiving a complaint on that same day, from a staff member to the Administrator. The report identified resident #002 as the resident involved in an incident of alleged abuse as outlined in the report and that the substitute decision-maker (SDM) had not been notified.

A review of the licensee's policy titled, "Zero Tolerance of Abuse and/or Neglect - ADM 450", last revised September 2014, indicated, "The Home will notify the resident's SDM, if any, and any other person the resident specifies:
(a) Immediately upon the home becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident, or distress to the resident that has the potential to be detrimental to the resident 's health and well-being; and
(b) Within 12 hours of becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident".

During an interview with the Administrator, they reported to the Inspector that they had not notified the SDM of the incident, involving resident #002, as it was hearsay, and it was not witnessed, but only verbally reported by PSW #104 to PSW #107. In addition, the Administrator reported that the SDMs of the residents that had been identified in incidents of alleged abuse, during the CIS investigation, were not notified. The Administrator reported that they had no dates, no times and no specific details and this was why the SDMs were not informed of the alleged abuse incidents. [s. 97. (1) (b)]

Additional Required Actions:

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

Issued on this 19th day of December, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2018_624196_0027
Log No. / No de registre :	026356-18, 026605-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 19, 2018
Licensee / Titulaire de permis :	Board of Management of the District of Kenora 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	Northwood Lodge 51 Highway 105, P.O. Box 420, RED LAKE, ON, P0V-2M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kandice Henry

To Board of Management of the District of Kenora, 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with LTCHA 2007, s. 20. (1)

The licensee must specifically:

a) Ensure that the licensee's written policy to promote zero tolerance of abuse and neglect of residents is complied with.
b) Provide training on the licensee's written policy to promote zero tolerance of abuse and neglect, including but not limited to, mandatory reporting and whistle-blowing protection, to all direct care staff members, and all registered staff members.
c) Maintain records of the content of the training provided, the name of the person responsible for the training, dates of the training and the names of the attendees.

Grounds / Motifs :

1. The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

The licensee submitted a Critical Incident System (CIS) report on a specific date in 2018, upon receiving a complaint on that same day, from a staff member to the Administrator. The report stated that PSW #108 had witnessed PSW #104 being abusive towards a resident but was unable to provide specific dates or times that the incidents had occurred. The report further identified that the

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During an interview, the Administrator confirmed to the Inspector that PSW #103, #105, #106, #107 and #108, had not followed the home's policy on "Zero Tolerance of Abuse and/or Neglect - ADM 450", specifically that incidents of alleged abuse were not immediately reported to an appropriate supervisor.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 2 as there

was a pattern. The home had a level 3 compliance history as there was one or more related non-compliance in the last 36 months as follows:
- a Written Notification (WN) was issued from a Resident Quality Inspection (RQI) #2018_395613_0014, on July 10, 2018. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 14, 2018

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 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, 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:

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 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 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

À l'attention du/de la registrateur(e) Commission d'appel et de revision des services de santé 151, rue Bloor Ouest, 9e étage Toronto ON M5S 1S4	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et 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 19th day of November, 2018

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Lauren Tenhunen

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