Ontario

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Dec 23, 2016	2016_295126_0026	030366-16	Complaint

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST SUITE 1500 TORONTO ON M5C 3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH P.O. BOX 1510 PRESCOTT ON K0E 1T0

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

LINDA HARKINS (126)

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): October 25, 26, 27, 28 and November 1, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Regional Extendicare Director, two Extendicare Nursing Consultants, Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), one Activity Aid(AA), one Union Representative, a family member and the resident.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **0 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	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. 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 when a person who had reasonable grounds to suspect that verbal/emotional abuse has occurred or may occur shall immediately report the suspicion to the Director, specially abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

In accordance with O. Reg. 79/10, s. 2(1) defines verbal and emotional abuse.

The definition of "verbal abuse" includes,
a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident

The definition of "emotional abuse" includes,
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

On October 25, 2016, Inspector # 126 initiated a complaint inspection for an allegation of

emotional and verbal abuse toward resident # 001 that occurred on a specific day in August 2016.

Resident #001 was admitted to the home on specific day of September 2010 with several diagnoses.

On a specific day of August 2016, AA #104 overheard RN #100 telling resident #001, "I am not catering to you if you stay in your room". AA #104 asked RN #100 why resident # 001 couldn't get a tray? RN #100 was observed by AA #104 raising her hands in the hair and told resident #001 that it was fine and that he/she could get a tray and continued saying to resident #001 that every time she worked the resident was always wanting to have the meal in his/her room. AA #104 indicated that resident #100 was upset about what RN #100 told him/her and continued on saying that it was that same nurse that removed the commode. Finally, AA #104 was able to bring resident #001 to the dining room.

On a specific day of August 2016, RN #100 documented in the progress notes that at lunch time, resident #100's family member called her, upset about a call received from resident #001 indicating that the resident was very upset and was crying. RN #100 went into resident #001 room to find resident sitting quietly in the easy chair. When asked if he/she was alright, resident #001 indicated that the side of his/her neck was sore and did not want to go to the dining room for lunch. RN# 100 informed resident #001 that he/she was now due for an analgesic which should help and suggested that resident #001 go to the dining room for lunch. Resident #001 was adamant that he/she did not wish to go and became upset, stating everyone caters to the roommate. Consequently, the roommate started yelling and cursing. Resident #001 started to cry and then agreed to go to the dining room.

On October 26, 2016, Inspector #126 interviewed AA #104 via telephone regarding the allegation of emotional and verbal abuse toward resident #001. AA #104 indicated that on a specific day of August 2016, around lunch time, she was assisting transferring residents to the dining room to go for lunch and was told that resident #001 was refusing to come for lunch in the dining room. As AA #104 was walking toward resident #001's bedroom she overheard RN #100 telling resident #001, "I am not catering to you if you stay in your room". AA #104 asked RN #100 why resident # 001 couldn't get a tray? RN #100 was observed by AA #104, raising her hands in the hair and told resident #001 that it was fine and that he/she could get a tray and continued saying to resident #001 that every time she worked resident # 001 was always wanting to have the meal in the

room. AA #104 indicated that she did not notified officially the management team because the Administrator/Director of Care had just left for lunch but she did mentioned it to her later that afternoon. AA #104 indicated that she had perceived this interaction between resident #001 and RN #104 being verbally inappropriate.

On October 26, 2016, Inspector # 126 had a discussion with resident #001 in the presence of a family member and could not recall the incident.

On November 1, 2016, Inspector #126 interviewed RN #100 who indicated that quite often resident #001 does not want to go to the dining room and that she would get him/her something else to eat. RN #100 could not specifically recall the incident of August 2016 but would not have said that she would not get a tray to resident #001.

On November 1, 2016, Inspector # 126 had a group discussion with the AA #104, the Regional Director of Extendicare, the Director of Care/Administrator and a Union Representative. The Regional Director indicated that she was informed of the incident when the Inspector came in the home to inspect this allegation. She indicated that she had a discussion with AA #104 and that she asked the AA #104 if it was abuse and AA #104 said no. AA #104 agreed with the discussion she had with the Regional Director. Inspector #126 referred them to the definition of emotional and verbal abuse as per the Long Term Care Home Act and they agreed the interaction could meet the definition and because it was suspected allegation that it should have been reported immediately.

At the time of the inspection, the licensee was working toward a compliance date of October 31, 2016 for an Order issued under the Long Term Care Home Act, 2007, S. O. 2007, c. 8, section. 19, Duty to protect. [s. 24. (1)]

Issued on this 6th day of January, 2017

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

Original report signed by the inspector.