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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 20, 2017	2017_572627_0016	019393-17	Resident Quality Inspection

Licensee/Titulaire de permis

The West Nipissing General Hospital
725 Coursol STURGEON FALLS ON P2B 2Y6

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

THE WEST NIPISSING GENERAL HOSPITAL
725 COURSOL STURGEON FALLS ON P2B 2Y6

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

SYLVIE BYRNES (627), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 18-22, 2017.

The following additional intakes that were submitted to the Director were inspected during this Resident Quality Inspection:

- One Critical Incident (CI) related to falls, and
- Two CIs related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Chief Nursing Officer (CNO), Long Term Care (LTC) Unit Manager, Social Worker (SW), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides (DAs), Activity Aides (AAs), Housekeeping staff (HK), family members and residents.

The Inspector(s) also conducted daily tours of the resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

8 WN(s)
5 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	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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents:
(d) contained an explanation of the duty under section 24 of the Act to make mandatory reports,
(f) set out the consequences for those who abused or neglected residents, and
(g) complied with any requirements respecting the matters provided for in clauses (a) through (f) that were provided for in the regulations.

On September 18, 2017, during a resident interview with Inspector #627, resident #005 alleged that a staff member had been inappropriate with them. They further stated that they had reported the incident to the Long Term Care (LTC) Unit Manager.

Inspector #627 reviewed the home's policy titled "Abuse of Residents/Patients –

Prevention, Reporting and Elimination of", policy #100.122, last revised June 2016, and noted that the policy had not contained the following:
(d) an explanation of the duty under section 24 of the Act to make mandatory reports,
(f) the consequences for those who abused or neglected residents,
(g) any requirements respecting the matters provided for in clauses (a) through (f) that were provided for in the regulations which included:

a) procedures and interventions to assist and support residents who had been abused or neglected or allegedly abused or neglected,

b) procedures and interventions to deal with persons who had abused or neglected or allegedly abused or neglected residents, as appropriate,

c) identified measures and strategies to prevent abuse and neglect,

d) identified the manner in which allegations of abuse and neglect were to be investigated, including who undertook the investigation and who was informed of the investigation, and

e) identified the training and retraining requirements for all staff, including i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care and ii) situations that may have led to abuse and neglect and how such situations could have been avoided.

Inspector #627 interviewed the Chief Nursing Officer (CNO) regarding the home's policy which promoted zero tolerance of abuse and neglect of residents. The CNO was asked to identify if the home's policy contained an explanation of the duty under section 24 of the Act to make mandatory reports, set out the consequences for those who abused or neglected residents and any requirements respecting the matters provided for in clauses (a) through (f) that were provided for in the regulations. The CNO confirmed that the policy had not included the above information and that they would be reviewing it. [s. 20. (2)]

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. 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 :

The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee and staff in the home.

During a resident interview with Inspector #627, resident #007 stated that there was an incident between them and an identified staff member, whereby the staff member had been verbally inappropriate with them. The resident stated they were offended and had discussed the incident with many other staff members.

Inspector #638 reviewed resident #007's health care records and identified a notation, which indicated that as a result of the incident, the resident would not participate in certain activities and the writer would discuss with management.

During an interview with Inspector #638, PSW #102 indicated that resident #007 made them aware of an incident. The PSW indicated that they had immediately approached the LTC Unit Manager with regards to the incident when they became aware of it.

During an interview with Inspector #638, SW #111 stated that resident #007 had informed them of an incident. SW #111 stated that they had reported the incident immediately to the LTC Unit Manager who had informed them that they would review it and bring it to the CNO's attention.

During an interview with Inspector #638, the LTC Unit Manager indicated that SW #111 may have approached them regarding the incident and that PSW #102 may have informed them of the incident between resident #007 and the identified staff member, however, they could not recall the incident and that it was a "miss" on their behalf for not following up with the incident. The LTC Unit Manager indicated that they had not recorded the incident or what was reported to them and no actions were taken because they hadn't remembered being notified of the incident. The LTC Unit Manager stated that if this incident was true, it was considered verbal abuse, however, they had not initiated an immediate investigation as they had not remembered being notified of the incident.

During an interview with the CNO, Inspector #638 reviewed the aforementioned incident between resident #007 and the identified staff member. The CNO indicated that they would have expected that an investigation be initiated, for resident #007 and the identified staff member to be interviewed regarding the situation to determine what had occurred and ensure that the alleged abuse was dealt with appropriately.

Additionally, the home failed to protect resident #007 from abuse and neglect as evidenced by noncompliance identified during this inspection related to:

-WN #1, LTCHA, 2007, s. 20 (2), where the licensee failed to ensure that the policy titled "Abuse of Residents/Patients – Prevention, Reporting and Elimination of", policy #100.122, last revised June 2016, was compliant with the requirements of the legislation.

- WN #3, finding '2', LTCHA, 2007, s. 23 (1) (a) where the licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, was immediately investigated.

- WN #4, LTCHA, 2007, s. 24 (1) where the licensee failed to ensure every alleged, suspected or witnessed incident that the licensee knew of, or was reported was immediately investigated. [s. 19. (1)]

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, was immediately investigated.

During a resident interview with Inspector #627, resident #005 alleged that a staff member had been inappropriate with them. Resident #005 stated that they had informed the LTC Unit Manager of the occurrence, as well as their family member.

Inspector #627 reviewed the care plan in effect at the time of the inspection and noted for the focus of activities of daily living (ADLs), staff were to ensure rights under dignity were met by ensuring a specific intervention.

Inspector #627 reviewed the home's policy titled "Abuse of Residents/Patients-Prevention, Reporting and Elimination of", policy #100.122, last revised June 2016, which indicated to "investigate immediately all incidents of alleged, suspected or witnessed abuse".

Inspector #627 interviewed the LTC Unit Manager who stated that they had found out about the incident from resident #005's family member. They further stated that the resident “may have spoken of it months ago but they had not provided a date”. They further stated that they had discussed it with the CNO, but as “there was no formal complaint, it had stopped there”, and no investigation had been completed.

Inspector #627 interviewed the CNO who stated that they had been made aware of the incident on a specified date. They stated that they were waiting for PSW #104 to return in order to interview them. They indicated that no investigation had been completed regarding this incident. [s. 23. (1) (a)]

2. During a resident interview with Inspector #627, resident #007 stated that there was an incident between them and a specified staff member. Please refer to WN #2 for additional details.

During an interview with Inspector #638, the LTC Unit Manager indicated that SW #111 may have approached them regarding the incident and that PSW #102 may have informed them of the incident between resident #007 and a specified staff member. They stated that they could not recall the incident and that it was a "miss" on their behalf for not following up with the incident. The LTC Unit Manager indicated that they had not recorded the incident or what was reported to them and no actions were taken because they didn't remember being notified of the incident. The LTC Unit Manager stated that this if this incident was true, it was considered verbal abuse, however, they had not initiated an immediate investigation as they had not remembered being notified of the incident.

During an interview with the CNO, Inspector #638 reviewed the aforementioned incident between resident #007 and the specified staff member. The CNO indicated that they would have expected that an investigation would have been initiated and the resident and the specified staff member be interviewed regarding the situation to determine what had occurred to ensure that the alleged abuse was dealt with appropriately.

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 every alleged, suspected or witnessed incident of abuse of a resident by anyone, is immediately investigated, to be implemented voluntarily.

WN #4: 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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, was reported was immediately investigated.

During a resident interview with Inspector #627, resident #005 alleged that a staff member had been inappropriate with them. Please see WN #3, finding '1' for details.

Inspector #627 reviewed the home's policy titled "Abuse of Residents/Patients – Prevention, Reporting and Elimination of", policy #100.122, last revised June 2016, which instructed to "report to the Director, Long-Term Care Home's Branch, all incidents of suspected or witnessed abuse, in accordance with the relevant Long Term Care legislation and this policy".

Inspector #627 interviewed the LTC Unit Manager who stated that they had found out about the event from the resident's family member. They further stated that the resident "may have spoken of it but they had not provided a date". They further stated that they had discussed it with the CNO, but as "there was no formal complaint, it had stopped there", and had not been reported to the Director.

Inspector #627 interviewed the CNO who stated that they had been made aware of the incident on a specified date. They stated that they were waiting for PSW #104 to return in order to interview them. They indicated that it had not been reported to the Director. [s. 24. (1)]

2. During a resident interview with Inspector #627, resident #007 stated that there was an incident between them and a specified staff member. Please see WN #2 for details.

During an interview with Inspector #638, PSW #102 indicated that resident #007 had made them aware of an incident between themselves and the specified staff member. PSW #103 stated that they had immediately approached the LTC Unit Manager with regards to the incident.

During an interview with Inspector #638, SW #111 stated that they were present when the resident #007 indicated that the specified staff member had been abusive to them. The SW stated that they immediately brought forward these concerns to the LTC Unit Manager and that the LTC Unit Manager had indicated that they would review the incident and bring to the CNO if needed.

During an interview with Inspector #638, the LTC Unit Manager indicated that SW #111 may have approached them regarding the incident and PSW #102 may have informed them of the incident between resident #007 and the specified staff member. The LTC Unit Manager stated that if this incident was true, it was considered abuse and that they had not reported the incident to the Director.

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 abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #008 was identified as having an area of altered skin integrity from their past to most recent Minimum Data Set (MDS) assessment.

Inspector #638 reviewed resident #008's health care records, specifically a "Wound Assessment and Treatment Record", which identified a newly developed area of altered skin integrity, on a specified date.

The Inspector reviewed the resident's completed "Wound Assessment and Treatment Record" for a period of three months and noted that the resident went unassessed for five periods of 10 to 23 days.

In an interview with Inspector #627, RPN #101 indicated that whenever a resident developed an area of altered skin integrity, they assessed the resident and completed a

wound assessment weekly.

Inspector #638 interviewed RPN #103 who indicated that resident #008 had ongoing altered skin integrity. Registered staff were expected to assess the area of altered skin integrity at least weekly until resolved. The RPN stated that the assessments were completed on Point Click Care (PCC) under the "Wound Assessment and Treatment Record" assessment form. The Inspector reviewed the completed "Wound Assessment and Treatment Record" with the RPN who stated that there should have been completed assessments for the aforementioned dates as the resident's areas of altered skin integrity had not resolved.

During an interview with Inspector #638, the LTC Unit Manager indicated that whenever a resident presented with an area of altered skin integrity, the registered staff were required to complete weekly pressure ulcer and skin and wound assessments. The Inspector reviewed resident #008's skin and wound assessments with the LTC Unit Manager who indicated that staff were required to complete weekly assessments. [s. 50. (2) (b) (iv)]

2. Resident #009 was identified as having an area of altered skin integrity from their past to most recent MDS assessment.

Inspector #627 completed a record review which identified an area of altered skin integrity, on a specific date, which had resolved approximately four weeks later.

Inspector #627 reviewed the home's policy titled "Wound Care", last revised on July 8, 2015, which identified that all patients at risk for skin breakdown or that had a documented wound were to have a skin/wound assessment done weekly.

The Inspector reviewed the wound assessments in PCC for resident #009, for a period of approximately four weeks, and noted two completed " Assessment and Treatment Records". The Inspector could not identify any assessments for the two other weeks when the resident remained with an area of altered skin integrity.

Inspector #627 interviewed RPN #101 who stated that resident #009 had an area of altered skin integrity since a specific date, which had resolved approximately four weeks later. They stated that when a resident had an area of altered skin integrity, a "Skin/Wound assessment" was to be completed weekly. This was entered in the electronic treatment administration record (ETAR), to ensure it was completed by all staff

on the specific day of the week. The assessment was completed in PCC. RPN #101 verified that an assessment should have been completed for the two other weeks when resident #009 had an area of altered skin integrity.

Inspector #627 interviewed the LTC Unit Manager who stated that when a resident has an area of altered skin integrity, the treatment and the weekly wound monitoring were to be entered in the Electronic Medication Record (EMAR). The staff were to document when the care had been provided. They confirmed that resident #008 should have had a skin/wound assessment weekly and had not on two separate dates, and one when the treatment was discontinued.

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 every resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tear or wounds is reassessed at least weekly by a member of the registered staff if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to residents received as a condition of continuing to have contact with residents, training in areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations.

Resident #009 was identified as having an area of altered skin integrity from the past to most recent MDS assessment.

The Long-Term Care Homes Act, 2007, Reg. 221 (2) stipulated that all staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following. 1) Subject to paragraph two, the staff must receive annual training in all areas required under subsection 76 (7) of the act. 2) If the licensee assessed the individual training needs of a staff member, the staff member was only required to receive training based on his or her assessed needs.

Inspector #627 interviewed PSW #108 and #109 who stated that they had not received any skin/wound care training in 2016. PSW #109 stated that they had received skin/wound care training in hospital however, they had not received any through the Long Term Care home. PSW #108 stated that they had received training for skin/wound care upon hiring during orientation, prior to 2016.

The Inspector interviewed RPN #107 who stated that they had taken part in a wound care course a few years ago (unsure of the year) which was taught by a wound care specialist, however they had not received any further training on skin/wound care since then.

Inspector #627 interviewed the CNO who stated that the home offered inservices on various wound care products to staff, (attendance was not mandatory) and every year, five to six staff members attended specialized would care courses, however training for skin and wound care was not provided in the home on a yearly basis, nor had they completed any testing to assess the staff's individual training needs. [s. 76. (7) 6.]

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 all staff who provided direct care to residents receive annual training for skin and wound care, or receive skin and wound care training based on his or her assessed needs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

Inspector #638 observed resident #003 with two specific types of restraints applied on two consecutive days.

During an interview with Inspector #638, PSW #102 indicated that whenever a resident was restrained by a physical device they required hourly monitoring which included, repositioning, releasing the restraint and ongoing monitoring. The PSW stated that the direct care staff documented restraint care in the "Restraint Administration Record".

Inspector #638 reviewed the "Restraint Administration Record" which indicated that the documentation for resident #003, #004, #012, #013, #014, #015, #016 and #017, had already been completed until 1400 hours that day (five and a half hours had been charted ahead of time with care being identified as being provided).

Inspector #638 reviewed the home's policy titled "Documentation – 605-101", last

reviewed June 6, 2017, which indicated that the standards for documentation included documenting in a timely manner and completing documentation as soon as possible after the care or event.

During an interview with Inspector #638, PSW #102 stated that the home's process for documenting on the "Restraint Administration Record" was to complete the charting for the entire shift at the beginning of the shift as it allowed them to spend more time with the residents. The PSW indicated that it was important to have accurate documentation and charting in advance may have caused discrepancies in what care was provided and what was documented as provided. PSW #102 stated that today, they had completed all the restraint documentation for all residents requiring restraints for their shift at 0600 hours. The PSW indicated that there was no "real good answer" as to why they completed the documentation early, that it was the direct care staffs' practice and they should have documented the care every hour or after the care was provided.

Inspector #638 interviewed RPN #107 who stated that the provision of care was expected to be documented as close as possible to the time the care was provided. The RPN indicated that it was not acceptable to document care prior to providing the care.

During an interview with Inspector #638, the CNO indicated that all documentation was completed in PCC or on paper for direct care staff. The CNO stated that charting was required to be completed closest to the time of care or as soon as possible after the care was completed. The CNO indicated that staff were expected to have their documentation completed in a timely manner but it was not acceptable to complete charting ahead of time as staff could not know what the resident's care would be in the future. [s. 231. (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 to ensure that the resident's written records are kept up to date at all times by ensuring that the care provided is documented as soon as possible after the care or the event, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

During an interview with Inspector #627, the CNO stated that the home did not have a family council. Letters informing the residents' families of the importance of a family council were sent out with the satisfaction survey yearly, and discussed with family members and persons of importance to the resident during the annual care conference, however, they had not held semi-annual meeting to advise such persons of the right to establish a Family Council. [s. 59. (7) (b)]

Issued on this 14th day of November, 2017

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

Original report signed by the inspector.

Ontario

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

Ministére 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) :	SYLVIE BYRNES (627), RYAN GOODMURPHY (638)
Inspection No. / No de l'inspection :	2017_572627_0016
Log No. / No de registre :	019393-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 20, 2017
Licensee / Titulaire de permis :	The West Nipissing General Hospital 725 Coursol, STURGEON FALLS, ON, P2B-2Y6
LTC Home / Foyer de SLD :	THE WEST NIPISSING GENERAL HOSPITAL 725 COURSOL, STURGEON FALLS, ON, P2B-2Y6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cynthia Desormiers

To The West Nipissing General Hospital, 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Order / Ordre :

The licensee shall review and revise the home's policy to promote zero tolerance of abuse and neglect of residents to ensure it complies with the requirement of the LTCHA and regulations and should include but not limited to:

1) Contain an explanation of the duty under section 24 of the Act to make mandatory reports,
2) set out the consequences for those who abused or neglected residents, and
3) complied with any requirements respecting the matters provided for in clauses (a) through (f) that were provided for in the regulations.

B) The policy shall be implemented and complied with.

C) All staff in the home shall receive training related to the policy to promote zero tolerance of abuse and neglect of residents.

D) A record is kept of the required training, including; when the training occurred, who was in attendance and what the training entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents:
(d) contained an explanation of the duty under section 24 of the Act to make mandatory reports,
(f) set out the consequences for those who abused or neglected residents, and
(g) complied with any requirements respecting the matters provided for in clauses (a) through (f) that were provided for in the regulations.

On September 18, 2017, during a resident interview with Inspector #627, resident #005 alleged that a staff member had been inappropriate with them. They further stated that they had reported the incident to the Long Term Care (LTC) Unit Manager.

Inspector #627 reviewed the home's policy titled "Abuse of Residents/Patients – Prevention, Reporting and Elimination of", policy #100.122, last revised June 2016, and noted that the policy had not contained the following:
(d) an explanation of the duty under section 24 of the Act to make mandatory reports,
(f) the consequences for those who abused or neglected residents,
(g) any requirements respecting the matters provided for in clauses (a) through

(f) that were provided for in the regulations which included:

a) procedures and interventions to assist and support residents who had been abused or neglected or allegedly abused or neglected,

b) procedures and interventions to deal with persons who had abused or neglected or allegedly abused or neglected residents, as appropriate,

c) identified measures and strategies to prevent abuse and neglect,

d) identified the manner in which allegations of abuse and neglect were to be investigated, including who undertook the investigation and who was informed of the investigation, and

e) identified the training and retraining requirements for all staff, including i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care and ii) situations that may have led to abuse and neglect and how such situations could have been avoided.

Inspector #627 interviewed the Chief Nursing Officer (CNO) regarding the home's policy which promoted zero tolerance of abuse and neglect of residents. The CNO was asked to identify if the home's policy contained an explanation of the duty under section 24 of the Act to make mandatory reports, set out the consequences for those who abused or neglected residents and any requirements respecting the matters provided for in clauses (a) through (f) that were provided for in the regulations. The CNO confirmed that the policy had not included the above information and that they would be reviewing it. [s. 20. (2)]

The decision to issue this compliance order was based on the scope which was identified as a widespread, the severity which was indicated a potential for actual harm and the compliance history indicated one or more unrelated noncompliance in the last three years. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 17, 2017

Order # / Ordre no : 002

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

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 shall ensure that all residents are protected from abuse by anyone and free from neglect by the licensee and staff in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee and staff in the home.

During a resident interview with Inspector #627, resident #007 stated that there was an incident between them and an identified staff member, whereby the staff member had been verbally inappropriate with them. The resident stated they were offended and had discussed the incident with many other staff members.

Inspector #638 reviewed resident #007's health care records and identified a notation, which indicated that as a result of the incident, the resident would not participate in certain activities and the writer would discuss with management.

During an interview with Inspector #638, PSW #102 indicated that resident #007 made them aware of an incident. The PSW indicated that they had immediately approached the LTC Unit Manager with regards to the incident when they became aware of it.

During an interview with Inspector #638, SW #111 stated that resident #007 had informed them of an incident. SW #111 stated that they had reported the incident immediately to the LTC Unit Manager who had informed them that they would review it and bring it to the CNO's attention.

During an interview with Inspector #638, the LTC Unit Manager indicated that

SW #111 may have approached them regarding the incident and that PSW #102 may have informed them of the incident between resident #007 and the identified staff member, however, they could not recall the incident and that it was a "miss" on their behalf for not following up with the incident. The LTC Unit Manager indicated that they had not recorded the incident or what was reported to them and no actions were taken because they hadn't remembered being notified of the incident. The LTC Unit Manager stated that if this incident was true, it was considered verbal abuse, however, they had not initiated an immediate investigation as they had not remembered being notified of the incident.

During an interview with the CNO, Inspector #638 reviewed the aforementioned incident between resident #007 and the identified staff member. The CNO indicated that they would have expected that an investigation be initiated, for resident #007 and the identified staff member to be interviewed regarding the situation to determine what had occurred and ensure that the alleged abuse was dealt with appropriately.

Additionally, the home failed to protect resident #007 from abuse and neglect as evidenced by non compliance identified during this inspection related to:

-WN #1, LTCHA, 2007, s. 20 (2), where the licensee failed to ensure that the policy titled "Abuse of Residents/Patients – Prevention, Reporting and Elimination of", policy #100.122, last revised June 2016, was compliant with the requirements of the legislation.

- WN #3, finding '2', LTCHA, 2007, s. 23 (1) (a) where the licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, was immediately investigated.

- WN #4, LTCHA, 2007, s. 24 (1) where the licensee failed to ensure every alleged, suspected or witnessed incident that the licensee knew of, or was reported was immediately investigated. [s. 19. (1)]

The decision to issue this compliance order was based on the scope which was identified as isolated, the severity which indicated actual harm and the compliance history which indicated one or more unrelated noncompliance in the last three years. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 03, 2017

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

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 20th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

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

Ministére 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

Name of Inspector / Nom de l'inspecteur : Sylvie Byrnes

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