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 prévue 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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## 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 |
|---|---|---|---|
| Jan 9, 2019 | 2018_668543_0027 | 022937-17, 008514-18, 011119-18, 024671-18 | Critical Incident System |

### Licensee/Titulaire de permis

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

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

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

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

TIFFANY BOUCHER (543), LOVIRIZA CALUZA (687)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): December 10-14, 2018**

**A Follow-up Inspection was completed concurrently with this Critical Incident System (CIS) Inspection.**

**The following intakes were inspected during the CIS inspection:**

**Three CIS reports the home submitted to the Director related to alleged abuse; and one CIS report the home submitted to the Director related to falls.**

**During the course of the inspection, the inspector(s) spoke with the Administrator/Chief Nursing Officer, Long-Term Care Unit Manager, Registered Practical Nurses (RPNs) Personal Support Workers (PSWs) and residents.**

**The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents and policies and procedures.**

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

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

A critical incident (CI) report was submitted to the Director regarding resident #003's fall that occurred on a day in 2018, which resulted in an injury to the resident.

A record review of the resident #003's current electronic care plan, indicated that the resident required intervention A applied at specific times throughout the day and that intervention A was to be removed at a specific time.

Inspector #687 interviewed resident #003 and the resident's substitute decision-maker (SDM), who indicated that the resident required intervention A at all times. The SDM checked for the application of the resident's intervention with the Inspector present, and verified that the resident did not have intervention A applied at that time.

During an interview with PSW #114, they indicated that the resident required intervention A at specific times throughout the day as indicated in the resident's care plan. The PSW further verified that they were unaware that the resident did not have intervention A applied at that time.

In an interview with RPN #104, they indicated that the resident required intervention A at specific times throughout the day and that intervention A was to be removed at specific times by a staff member.

In an interview with the LTC unit manager they verified that the written care plan should be followed by all staff. They verified that the staff who had not applied the resident's intervention had not provided care as specified in the resident's care plan. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A CI report was submitted to the Director regarding resident #003's fall that occurred on a day in 2018, which resulted in an injury to the resident.

Inspector #687 reviewed the resident's current care plan; under the focus for falls, the care plan indicated that staff were to ensure that intervention B was applied for resident #003 as a result of an injury.

During an observation, Inspector #687 observed resident #003 in the dining room without intervention B applied.

Inspector #687 reviewed the home's policy titled, "Resident Care Plan" last reviewed June 2017, which indicated that the plan of care was to be revised at least quarterly and whenever there was a change in the resident's health status, ability or needs.

In a record review of the physician's order sheet the Inspector identified that intervention B had been discontinued.

During an interview with RPN #104, they verified that resident #003 no longer required intervention B, as it had been discontinued by the physician.

In an interview with the LTC unit manager, they verified that the physician's order to discontinue resident #003's intervention B was carried on; however, it was not transcribed in the update of the resident's care plan which should have been done when the resident's care needs had changed. [s. 6. (10) (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 compliance that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #2: 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 the home's policy to promote zero tolerance of abuse was complied with.

The home submitted a CI report to the Director, which outlined an allegation of abuse of resident #005 by an unknown individual on a date in 2018.

Inspector #687 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect" revised date September 21, 2018, which indicated that the LTC unit manager and the Chief Nursing Officer as soon as possible were to initiate a full investigation of the incident which included "interviewing the person(s) reporting the abuse".

During an interview conducted by Inspector #687 with PSW #107, they verified that they were working on the date the alleged incident occurred in 2018, and that the resident informed them of the alleged incident. The PSW consoled the resident and reported the incident to a registered staff member; they could not recall providing information or an interview of the alleged incident of resident #005 to management.

In an interview with the Unit Manager, they verified that they completed and revised the internal investigation report specific to the alleged incident that occurred in 2018; RPN #105 was interviewed but PSW #107 was not interviewed in relation to the alleged incident reported by resident #005. The LTC unit manager stated that based on the "Zero Tolerance of Abuse and Neglect" policy, the information and the recollection of events from PSW #107 was vital to their internal investigation report and that they should have interviewed the PSW. [s. 20. (1)]

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that an incident of alleged abuse was immediately reported to the Director.

The home submitted a CI report to the Director, which outlined an allegation of abuse of resident #005 by an unknown individual on a day in 2018.

During the inspection, Inspector #687 reviewed the home's internal investigation documents related to the alleged incident that occurred on that day in 2018. The Inspector identified that the Nursing Manager was made aware four days after the incident, of a previous alleged incident of abuse which had occurred nearly five months prior. The document detailed that the resident's family member had spoken to RPN #112, PSW #113 and BSO #106 during an internal investigation. The notes described that the family member assumed that the staff member would follow the appropriate reporting steps about the previous incident.

In a record review of resident #005's electronic progress notes it indicated that physician #118 was made aware and had assessed the resident for the alleged abuse incident. The progress notes further indicated that the incident was discussed with the family.

During an interview with Inspector #687, BSO #106 verified that resident #005 stated that they had been abused. The BSO staff member comforted the resident and indicated that they verbally reported this alleged abuse incident to the Chief Nursing Officer (CNO) but had not documented the events.

During an interview with the CNO, they indicated that they were not made aware of the previous incident until a meeting with the resident's family, the police and the LTC unit manager. The CNO indicated that the BSO staff #106 had not reported the alleged abuse incident of resident #005 when it had occurred.

In an interview with the Inspector, the Unit Manager stated that they were not aware of resident #005's alleged abuse incident and had come to learn nearly five months later, during their internal investigation meeting with the resident's family, the CNO and the police. The LTC unit manager indicated that a separate CI report should have been completed for resident #005's alleged abuse incident that had occurred. [s. 24. (1)]

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**Issued on this 10th day of January, 2019**

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

**Original report signed by the inspector.**