Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 24, 2021	2021_841679_0003	022832-20, 000891-21, 002042-21	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

MICHELLE BERARDI (679), SYLVIE BYRNES (627)

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): February 1-5 and 8-10, 2021.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:

- Two intakes related to allegations of staff to resident abuse; and,
- One intake related to resident to resident abuse.

A Complaint Inspection #2021_841679_0004 was conducted concurrently with this inspection.

A Compliance Order related to s. 5 of the Long-Term Care Homes Act 2007, was identified in this inspection and has been issued in Complaint Inspection Report #2021_841679_0004, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Clinical Nurse Manager, Manager of Infection Prevention and Control, Human Resources (HR) Manager, Pharmacist, Behavioural Supports Ontario (BSO), Clinical Educator/Head Nurse, Staffing Officer, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreation Therapist, Housekeepers, COVID-19 screeners, residents and family members.

The Inspectors also conducted a daily tour of resident care areas, observed infection prevention and control (IPAC) practices, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.

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

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

11 WN(s)
6 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	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from abuse by a staff member.

Emotional abuse is defined within the Ontario Regulation 79/10, as “any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that is performed by anyone other than a resident”.

Financial abuse is defined within the Ontario Regulation 79/10, as any misappropriation or misuse of a resident’s money or property.

A Critical Incident System (CIS) report was submitted to the Director for an allegation of staff to resident abuse.

a) Inspector #679 reviewed a report which detailed a number of concerns between the resident and the staff member. The report indicated that the actions of the staff member resulted in emotional distress for the resident.

b) The home's Zero Tolerance of Abuse and Neglect Program, last revised December 20, 2019, indicated that during the investigation, staff involved in the alleged, suspected or witnessed abuse or neglect will be immediately removed from the care area and reassigned or suspended under the direction of the HR Department. A review of a typed interview with the staff member indicated they were provided direction to not interact with the resident; however, in an interview with the Clinical Nurse Manager, they indicated that the staff member did not follow this direction.

The Clinical Nurse Manager indicated the allegation of abuse was substantiated, and that

the resident remained affected from this incident.

c) Upon review of the staff member's personnel file, the Inspector identified a letter which detailed a previous incident involving a different resident and the staff member.

d) During the home's investigation into an allegation of staff to resident abuse, the Clinical Nurse Manager, was informed that the staff member had charged a resident for a specified service. The Clinical Nurse Manager indicated to the Inspector, that the home had an individual who conducted the service in the home. The Clinical Nurse Manager indicated that the resident had not arranged any process through the home for payment, and that they were able to confirm that the resident had paid cash to the staff member who provided the specified services while on shift.

Sources: CIS report; Review of the home's internal investigation notes; Zero Tolerance of Abuse and Neglect Program, last revised December 20, 2019; Interviews with the Manager of Clinical Services and other staff. [s. 19. (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. 6. Plan of care

Specifically failed to comply with the following:

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 plan of care was reviewed and revised when three residents' care needs changed.

a) During separate interviews with two staff members, they indicated that a resident was to be transferred using a specified transfer device.

The resident's current care plan indicated that they transferred with staff assistance via a different transfer aid.

The Clinical Nurse Manager acknowledged that the resident's care plan should be updated to indicate they required the specified transfer device.

Sources: Interview with staff members and the Clinical Nurse Manager; A resident's current care plan; “Resident Care Plan (#605-166)" policy, last reviewed July 2019.

b) In separate interviews, two staff members stated that a resident utilized a specified mobility aid.

A review of the resident’s current care plan, for the focus of mobility indicated that the resident needed assistance with ambulation via a different mobility aid.

Sources: Interviews with staff members; A resident’s current care plan; "Resident Care Plan (#605-166)" policy, last reviewed July 2019.

c) A resident was observed using a mobility device with two specified interventions in place.

A review of the resident’s care plan indicated the resident utilized a different mobility device. Additionally, the resident's care plan did not include the use of the two specified interventions observed.

In separate interviews with two staff members, they stated that the resident had two specified interventions. They also stated that the resident did not utilize the mobility device outlined in their care plan. The staff members acknowledged that the resident's care plan should be updated.

Sources: Observations; Interviews with staff members and the Clinical Nurse Manager; A resident's current care plan; “Resident Care Plan (#605-166)" policy, last reviewed July 2019. [627] [s. 6. (10) (b)]

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. 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 written policy to promote zero tolerance of abuse and neglect of residents was complied with, related to the reporting of an incident of resident to resident abuse.

The home's Zero Tolerance of Abuse and Neglect policy required staff to immediately report any alleged, suspected or witnessed incident of abuse of a resident by anyone to the unit manager or delegate.

A CIS report was submitted to the Director for an incident of resident to resident abuse which occurred a day prior to the submission of the CIS report. A review of a letter addressed to a staff member indicated that they had brought forth the concern regarding the incident the following day, that this incident constituted an act of resident abuse that was reportable to the Ministry of Long-Term Care and that their action was in violation of the policy titled "Zero Tolerance of Abuse and Neglect". In an interview with the Clinical Nurse Manager they indicated that staff were to report suspected abuse to the charge nurse, and that the staff member did not report in a timely fashion.

Sources: A CIS report; Two residents electronic medical records, including progress notes; Zero Tolerance of Abuse and Neglect Program, revised December 20, 2019; Investigation Notes; Interviews with the Manager of Clinical Services and other staff. [s. 20. (1)]

2. Staff documented an incident involving two residents. In an interview with both the Head Nurse/Clinical Educator and the Clinical Nurse Manager, they indicated they were not made aware of this incident. The Clinical Nurse Manager indicated that a CIS report was not submitted related to this incident, and that this incident should have been reported to the management team as it had a negative impact on the resident and could be considered verbal abuse.

Sources: Health Records for two residents; Zero Tolerance of Abuse and Neglect Program, revised December 20, 2019; Interview with the Clinical Nurse Manager, and other staff. [s. 20. (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 ensuring that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour program was evaluated annually.

Inspector #679 requested to review the home’s evaluation of the home’s responsive behaviour program. The Clinical Nurse Manager indicated that the program review had not been completed since 2018.

Sources: Interview with the Clinical Nurse Manager. [s. 53. (3) (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 ensuring that at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices, and, if there are none, in accordance with prevailing practices, and a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between two residents by identifying factors based on an interdisciplinary assessment that could potentially trigger such altercations.

Staff documented an incident between two residents. In separate interviews with two staff members, they both indicated a history of incidents between the two residents. Inspector #679 reviewed the care plan for both residents, and did not identify information related to the potential for incidents between these two residents.

In an interview with the Clinical Nurse Manager, they indicated that a staff member would reference a resident's care plan to determine if the resident exhibited responsive behaviours and interventions to manage these behaviours. The Clinical Nurse Manager indicated that there should be information surrounding the interactions of these two residents within the care plan.

Sources: Two resident's electronic records, including: progress notes and care plan; Interviews with the Clinical Nurse Manager and other staff; Identification of Aggressive Behaviours, Assessment and Response policy (100-139) with a review date of July 14, 2019. [s. 54. (a)]

2. The licensee has failed to ensure that steps were taken to minimize the risk of altercations between two residents, including identifying and implementing interventions.

A resident's progress notes identified potentially harmful interactions which occurred between two residents on a number of dates. The Inspector did not identify any interventions trialed to minimize the risk of altercations until interventions were implemented on a specified date. In an interview with a staff member, they indicated the interventions to prevent altercations between the two residents were implemented recently, as the prior incidents were negative, but not aggressive. A staff member confirmed the interventions were put into place on the specified date.

Sources: A CIS report; Two resident's electronic records, including progress notes and care plan; Interviews with staff members. [s. 54. (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 ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including: (a) identifying factors, based on an interdisciplinary assessment and on the information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and, (b) identifying and implementing interventions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

Inspector #679 requested to review the home’s evaluation of the home’s policy to promote zero tolerance of abuse and neglect program. The Clinical Nurse Manager indicated that the program review had not been completed since 2018.

Sources: Interview with the Clinical Nurse Manager. [s. 99. (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 ensuring that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and the changes and improvements required to prevent further occurrences, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that medicated creams and insulin were stored in an area that was secured and locked.

On multiple occasions, several medicated creams were identified in an unlocked cabinet. Further, on one occasion an insulin pen was observed in a resident area. The Clinical Nurse Manager confirmed that the cupboard which contained the medicated creams was to be locked, and the insulin was to be stored in a locked medication cart.

Sources: Inspector #679's observations; Medication Administration & Storage Policy (605 -32) dated November 6, 2019; Interviews with the Clinical Nurse Manager and other staff. [s. 129. (1) (a) (ii)]

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 ensuring that drugs are stored in an area or medication cart that is secured and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control program was evaluated and updated at least annually.

Inspector #679 requested to review the home's annual review of the IPAC program. The Manager of IPAC indicated that the home did not complete a formal IPAC program review.

Sources: Interview with the Manager of IPAC. [s. 229. (2) (d)]

2. The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program, related to hand hygiene.

The licensee's IPAC program required staff to ensure that residents were encouraged to wash their hands before eating and drinking. During two meal observations the Inspector observed that not all residents were assisted with performing hand hygiene prior to being served their meal. When asked if residents were assisted with performing hand hygiene before and after meal services, a staff member identified that staff were supposed to assist residents with hand hygiene. In an interview with the Manager for IPAC, they indicated that residents were to be encouraged to perform hand hygiene at meal times.

Sources: Inspector #679 observations; Ontario's Just Clean Your Hands Implementation Guide; Hand Hygiene Policy (738.47) which a revised date of December, 2017; Interviews with the Manager for IPAC and other staff. [s. 229. (4)]

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 ensuring that the IPAC program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and, ensuring that staff participate in the implementation of the IPAC program, to be implemented voluntarily.

WN #9: 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident that resulted in harm had immediately reported the suspicion and the information upon which it was based to the Director.

A progress note written by the Head Nurse/Clinical Educator indicated an incident had occurred between two residents. A review of the CIS report indicated this information was reported to the Director three days after the occurrence. In an interview with the Clinical Nurse Manager, they indicated the process for reporting allegations of abuse or neglect would be to report the information to management, review the decision tree for reporting and either the Clinical Nurse Manager or Clinical Educator would report to the Director.

Sources: CIS report; A resident's electronic records, including progress notes; Interview's with two residents; Zero Tolerance of Abuse and Neglect Program, revised December 20, 2019; Staff interviews. [s. 24. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's care plan included their need for an intervention.

Inspector #679 observed signage outside a resident room. A staff member indicated that the resident required a specified intervention. The Inspector reviewed the resident's electronic care plan and did not identify a focus or interventions related to the need for the intervention, or the diagnosis for which the resident required the intervention. The Manager for IPAC indicated the requirement for the intervention would be identified outside the resident's door and in their care plan.

Sources: Inspector #679's observation; A resident's care plan; Interviews with the Manager of IPAC and other staff. [s. 26. (3) 18.]

WN #11: 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 two resident's written records were kept up to date at all times.

An incident was documented between two residents. A number of days later, a staff member completed a follow up progress note to correct their previous documentation in both resident's electronic medical records. The Clinical Nurse Manager indicated documentation was to be completed as soon as possible, after an event happened.

Sources: Two resident's electronic records, including progress notes; Interview with the Clinical Nurse Manager and other staff. [s. 231. (b)]

Issued on this 13th day of April, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	MICHELLE BERARDI (679), SYLVIE BYRNES (627)
Inspection No. / No de l’inspection :	2021_841679_0003
Log No. / No de registre :	022832-20, 000891-21, 002042-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 24, 2021
Licensee / Titulaire de permis :	The West Nipissing General Hospital 725 chemin Coursol Road, Sturgeon Falls, ON, P2B-2Y6
LTC Home / Foyer de SLD :	The West Nipissing General Hospital 725 chemin Coursol Road, Sturgeon Falls, ON, P2B-2Y6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Cynthia Desormiers

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

To The West Nipissing General Hospital, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

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 must be compliant with s. 19. (1) of the Long-Term Care Home's Act, 2007.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that residents of the home are protected from abuse by anyone and that residents are not neglected by the licensee or staff.

The plan must include but is not limited to:
- How the licensee will ensure that staff are aware of the relationship of 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, situations that may lead to abuse and neglect and how to avoid such situations.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was protected from abuse by a staff member.

Emotional abuse is defined within the Ontario Regulation 79/10, as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that is performed by anyone other than a resident".

Financial abuse is defined within the Ontario Regulation 79/10, as any misappropriation or misuse of a resident's money or property.

A Critical Incident System (CIS) report was submitted to the Director for an

allegation of staff to resident abuse.

a) Inspector #679 reviewed a report which detailed a number of concerns between the resident and the staff member. The report indicated that the actions of the staff member resulted in emotional distress for the resident.

b) The home's Zero Tolerance of Abuse and Neglect Program, last revised December 20, 2019, indicated that during the investigation, staff involved in the alleged, suspected or witnessed abuse or neglect will be immediately removed from the care area and reassigned or suspended under the direction of the HR Department. A review of a typed interview with the staff member indicated they were provided direction to not interact with the resident; however, in an interview with the Clinical Nurse Manager, they indicated that the staff member did not follow this direction.

The Clinical Nurse Manager indicated the allegation of abuse was substantiated, and that the resident remained affected from this incident.

c) Upon review of the staff member's personnel file, the Inspector identified a letter which detailed a previous incident involving a different resident and the staff member.

d) During the home's investigation into an allegation of staff to resident abuse, the Clinical Nurse Manager, was informed that the staff member had charged a resident for a specified service. The Clinical Nurse Manager indicated to the Inspector, that the home had an individual who conducted the service in the home. The Clinical Nurse Manager indicated that the resident had not arranged any process through the home for payment, and that they were able to confirm that the resident had paid cash to the staff member who provided the specified services while on shift.

Sources: CIS report; Review of the home's internal investigation notes; Zero Tolerance of Abuse and Neglect Program, last revised December 20, 2019; Interviews with the Manager of Clinical Services and other staff.

An order was made by taking the following factors into account:

Severity: Actual harm was identified related to this incident of staff to resident abuse, as the home indicated the resident remains affected by this incident.

Scope: The scope of this non-compliance was isolated as it related to one incident reviewed.

Compliance History: One Compliance Order (CO) which had been complied, two Voluntary Plans of Correction (VPCs) and three Written Notifications (WNs) were issued to the home related to different sub-sections of the legislation in the past 36 months. (679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 06, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 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. 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with s. 6 (10). of the Long-Term Care Home's Act, 2007.

Specifically, the licensee shall review and update three resident's plan of care to ensure it reflects each resident's current care needs.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care was reviewed and revised when three residents' care needs changed.

a) During separate interviews with two staff members, they indicated that a resident was to be transferred using a specified transfer device.

The resident's current care plan indicated that they transferred with staff assistance via a different transfer aid.

The Clinical Nurse Manager acknowledged that the resident's care plan should be updated to indicate they required the specified transfer device.

Sources: Interview with staff members and the Clinical Nurse Manager; A resident's current care plan; "Resident Care Plan (#605-166)" policy, last reviewed July 2019.

b) In separate interviews, two staff members stated that a resident utilized a specified mobility aid.

A review of the resident's current care plan, for the focus of mobility indicated that the resident needed assistance with ambulation via a different mobility aid.

Sources: Interviews with staff members; A resident's current care plan; "Resident Care Plan (#605-166)" policy, last reviewed July 2019.

c) A resident was observed using a mobility device with two specified interventions in place.

A review of the resident's care plan indicated the resident utilized a different mobility device. Additionally, the resident's care plan did not include the use of the two specified interventions observed.

In separate interviews with two staff members, they stated that the resident had two specified interventions. They also stated that the resident did not utilize the mobility device outlined in their care plan. The staff members acknowledged that the resident's care plan should be updated.

Sources: Observations; Interviews with staff members and the Clinical Nurse Manager; A resident's current care plan; "Resident Care Plan (#605-166)" policy, last reviewed July 2019. [627]

An order was made by taking the following factors into account:

Severity: Minimal risk was identified in the home related to three resident's plan of care not being update to reflect their current mobility, fall and safety needs.

Scope: The scope of this non-compliance was a pattern, as it related to 38 percent of resident's reviewed.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (10) and one VPC was issued to the home. (679)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : May 06, 2021

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 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:

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

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

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 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 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 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 24th day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Michelle Berardi

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