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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 5, 2015	2014_200148_0041	O-000782-14	Complaint

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

WOODLAND VILLA
30 Milles Roches Road R. R. #1 Long Sault ON K0C 1P0

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 25 and 26, 2014, on site.

This inspection included information provided through a critical incident report.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Interim Director of Care (DOC), Registered Nursing Staff, Personal Support Workers (PSW), Office Manager, residents and family members.

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 failed to ensure that the home protected Resident #1 and #2 from abuse by anyone.

In accordance with O.Reg. 79/10, section 2, emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

As demonstrated by this inspection report the home failed to protect residents from abuse in that:

The Administrator and DOC did not follow the policy to promote zero tolerance of abuse and neglect of residents, as indicated by WN #2. This notification indicates that reporting procedures, including reporting to the Director, OMNI Home Office and resident substitute decision makers (SDMs) were not followed. In addition, procedures describing the removal of an employee alleged to have committed an abusive act from the work environment was not followed. Further to this, the lead for the home's investigation, identified as the home's DOC, was unfamiliar with the home's policy to promote zero tolerance of abuse and neglect of residents and related investigative and reporting policies.

The home's policy does not provide for a clear explanation of the duty under s.24 to make mandatory reports, as indicated by WN #2. This inspection demonstrates that staff members and managers had information related to the alleged incident of abuse involving Resident #1, however, a report of the alleged abuse was not provided to the Director until 35 days after the alleged incident, as noted in WN #3. In addition, with the exception of Inspector #148's discovery of the incident involving Resident #2, no person had made a report to the Director prior to November 25, 2014, related to the incident involving Resident #2.

Notification was not provided, as required, to the resident's SDM(s), related to the alleged incidents of abuse or the conclusions of the investigation, as indicated by WN #5. In addition, after the home was approached by family members of Resident #1, neither, the Administrator or DOC made contact with the SDM of Resident #2, as of December 5, 2014. The DOC indicated that the SDMs were not informed of the investigation as the incident was alleged and the investigation concluded insufficient evidence to support abuse occurred.

The home did not put in place interventions to ensure that Resident #1 and Resident #2 were protected from abuse pending the investigation.

The DOC acknowledges the delay of reporting by PSW #S102 and the known care issues with PSW #S101, however, cannot demonstrate that any action was taken with respect to re-education for either staff member. Further, the home cannot demonstrate that PSW #S101 has been provided education on the policy to promote zero tolerance of abuse and neglect of residents within the last year or upon return from an extend leave of absence, as per WN #4.

The Administrator and DOC failed to follow up with all leads of information including potential information held by PSW #S103 related to the incident of alleged abuse of Resident #1. When followed up by Inspector #148, the information held by PSW #103 lead to another staff member with potential information about the alleged incident of abuse of Resident #1, of which the home was not aware.

In addition, the home concluded insufficient evidence existed to support that abuse occurred, despite the history of care complaints related to PSW #S101 and that both incidents were witnessed by a credible witness, as described by the DOC.

On a specified date, PSW #S102 witnessed two incidents; one involving the care provided to Resident #1 by PSW #S101 and a second involving the care provided to Resident #2 by PSW #S101. While providing dressing and continence care to Resident #1, PSW #S101 was witness to push and shove the resident roughly. The resident became upset and indicated that he/she was being hurt, the resident was re-visited by PSW #S102 moments later and was still crying over the incident. While providing transfer assistance to Resident #2, the resident indicated that his/her right shoulder was in tremendous pain and that he/she was being hurt and asked to be lowered. PSW #S101 was witnessed to ignore the residents' complaints and told the resident, that he/she would have to wait until the transfer was complete. PSW #S102 reported that the right side of the sling, located on the side in which PSW #S101 was responsible, was not under the armpit but rather under the arm folds. Resident #1 was not able to recall the incident. Resident #2 reported to the DOC, during the investigation, that his/her arm was sore for a day or two after the incident.

Two days after the incidents, PSW #S102 reported information to PSW #S103, through text message, about the incident involving Resident #1, that would be considered

reasonable grounds to suspect abuse. PSW #S102 also reported information to the home's Office Manager about the incident involving Resident #1 that may also have been reasonable grounds to suspect abuse. PSW #S102 left a voice message with the home's DOC, without indicating specific information about either incident. The DOC returned the call and on the same date met with PSW #S102 at which time witness reports were completed describing both incidents involving Resident #1 and #2 and staff member PSW #S101.

The DOC initiated an investigation which included interviews with PSW #S101 and PSW #S102 and Residents #1 and #2, health care record reviews and a review of PSW #S101 employee file. Staffing schedules and an interview with PSW #S101, indicate that PSW #S101 continued to work with Resident #1 and #2 during the time frame of the investigation. The DOC confirmed no measures were put in place to ensure the safety of Resident #1 and #2 pending the investigation. The Administrator and DOC acknowledged that PSW #S101 has a history of complaints related to resident care from family, staff and residents. The DOC reported to Inspector #148, that PSW #S102 was considered a credible witness with no reason to provide false information. The investigation concluded there to be insufficient evidence to support abuse had occurred in either case involving Resident #1 and Resident #2. It was further reported by the DOC, that although they could not substantiate that abuse had occurred, that re-education to PSW #S101 and PSW #S102 was provided. The home could not demonstrate that this re-education had occurred; PSW #S101 could not recall having been provided re-education regarding the described alleged incidents of abuse.

Twenty-seven days after the incident, a family member of Resident #1 approached the Administrator and DOC about information obtained while in the community about an incident of alleged abuse involving Resident #1. During this meeting the family member requested that PSW #S101 be removed from the care of Resident #1, the home implemented this request on the same date. The day after the primary substituted decision maker (SDM) of Resident #1 also approached the DOC, acknowledging that the SDM(s) of Resident #1 had not been informed by the Administrator or DOC, of any alleged abuse involving Resident #1. Inspector #148 spoke with the SDM of Resident #1 who indicated that no notification had been given, by the Administrator or DOC, of the alleged incident or that the home had initiated, conducted and concluded an investigation related to the incident.

Inspector #148 spoke with the SDM of Resident #2. The SDM of Resident #2 indicated that at the time of the inspector's interview, no notification had been provided of the

alleged incident of abuse involving Resident #2 or that the home had initiated, conducted and concluded an investigation related to the alleged incident.

In addition, the SDM of Resident #1 informed the DOC that PSW #S103 had information pertaining to the alleged incident involving Resident #1. The Administrator acknowledged to Inspector #148, that he was aware of this information. The DOC confirmed with Inspector #148, on November 26, 2014, that PSW #S103 had not been spoken to as part of the home's investigation.

On a specified date, the family member of Resident #1 contacted the Director, through means of the ActionLine, and reported information of a suspected abuse involving Resident #1.

After having received the information from the ActionLine, Inspector #138, phoned the home's Administrator with respect to the information provided by the family member of Resident #1. On the same date, after the call from Inspector #138, the home's DOC spoke with a representative from OMNI Home Office and submitted a Critical Incident Report to the Director (Ministry of Health and Long Term Care) related to the incident involving Resident #1. The DOC confirmed that no other manner of report was made to the Director, related to the incidents of alleged abuse of Resident #1, until 30 days after the incident was reported to the DOC.

The incident involving Resident #2 was discovered by Inspector #148 during this complaint inspection. It was confirmed with the DOC, that prior to Inspector #148's arrival to the home on November 25, 2014, no person had reported the incident involving Resident #2, to the Director. [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. 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).

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 :

The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents, is complied with.

As identified by the home's Administrator, the policy titled Zero Tolerance of Abuse and Neglect of Residents, #AM-6.9, effective September 2013 is the licensee's policy to promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act. Policy #AM-6.9 references the Investigation Procedure policy, #AM-6.3 and further to this the Reporting of Abuse policy, #AM-6.7.

Policy #AM-6.9 states that every incidence of alleged, suspected or witnessed neglect or abuse shall be immediately reported, by the home, to OMNI Home Office and the

Ministry of Health and Long Term Care upon learning of such an incident.

Policy #AM-6.9 states that any person who has reasonable grounds to suspect that a resident has been neglected or abused is to immediately report the suspicion to the home's Administrator or appropriate designate (procedure defines as direct manager or DOC).

Policy #AM-6.9 states that an employee alleged to have committed an abusive or neglectful act shall immediately be removed from the work environment pending investigation.

On a specified date, PSW #S102 witnessed two incidents; one involving the care provided to Resident #1 by PSW #S101 and a second involving the care provided to Resident #2 by PSW #S101. While providing dressing and continence care to Resident #1, PSW #S101 was witness to push and shove the resident roughly. The resident became upset and indicated that he/she was being hurt, the resident was re-visited by PSW #S102 moments later and was still crying over the incident. While providing transfer assistance to Resident #2, the resident indicated that his/her right shoulder was in tremendous pain and that he/she was being hurt and asked to be lowered. PSW #S101 was witnessed to ignore the residents' complaints and told the resident, that he/she would have to wait until the transfer was complete. PSW #S102 reported that the right side of the sling, located on the side in which PSW #S101 was responsible, was not under the armpit but rather under the arm folds.

Two days after the incidents, PSW #S102 reported information to PSW #S103, through text message, about the incident involving Resident #1, that would be considered reasonable grounds to suspect abuse. PSW #S102 also reported information to the home's Office Manager about the incident involving Resident #1 that may also have been reasonable grounds to suspect abuse. PSW #S102 left a voice message with the home's DOC, without indicating specific information about either incident. The DOC returned the call and on the same date met with PSW #S102 at which time witness reports were completed describing both incidents involving Resident #1 and #2 and staff member PSW #S101.

The DOC initiated an investigation. Staffing schedules and an interview with PSW #S101, indicate that PSW #S101 continued to work with Resident #1 and #2 during the time frame of the investigation.

Twenty-seven days after the incident, a family member of Resident #1 approached the Administrator and DOC about information obtained while in the community about an alleged incident of abuse involving Resident #1. The day after, the primary SDM of Resident #1 also approached the DOC, acknowledging that the SDM(s) of Resident #1 had not been informed by the Administrator or DOC of any alleged abuse involving Resident #1. In addition, it was confirmed that the substitute decision maker for Resident #2 was not informed of the alleged incident, nor were either the SDM for Resident #1 or #2, informed of the home's conclusions immediately following the home's investigation.

Thirty days after the incident was reported to the DOC, the home's DOC spoke with OMNI Home Office and submitted a Critical Incident Report to the Director (Ministry of Health and Long Term Care) related to the incident involving Resident #1. The DOC confirmed that no other manner of report was made to OMNI Home office or the Director until this time. The incident involving Resident #2 was discovered by Inspector #148 during this complaint inspection, prior to the Inspector's arrival to the home on November 25, 2014, no person had reported the incident involving Resident #2, to the Director.

The home did not comply with the licensee's policy to promote zero tolerance of abuse, in that the home did not immediately report the alleged incidents of abuse to the Director or to the OMNI Home Office, nor did staff members of the home immediately report the suspicion of abuse to the home's Administrator or appropriate designate. In addition, staff member PSW #S101, was not removed from the work environment pending investigation and continued to work with Resident #1 and #2.

The lead for the home's investigation was identified as the DOC. The DOC was not aware of the Investigation Procedures, policy #AM- 6.3, which indicates the procedures to follow when conducting an investigation. The Reporting Incidents of Abuse policy, # AM-6.7, was referenced by the Investigation Procedures policy, which indicates the Ministry of Health are to be immediately notified of alleged, suspected or witnessed incidents of abuse or neglect, that the family or substitute decision maker shall be contacted to inform them of any alleged, suspected or witnessed abuse or neglect immediately after it is reported and subsequently contacted to notify them of the results of any investigation conducted. Neither of these items referenced in the Reporting Incidents of Abuse were complied with. [s. 20. (1)]

2. The licensee did not ensure that, at a minimum, the written policy to promote zero tolerance of abuse and neglect of residents, shall (d) contain an explanation of the duty under section 24 to make mandatory reports.

As identified by the home's Administrator, the policy titled Zero Tolerance of Abuse and Neglect of Residents, #AM-6.9, effective September 2013 is the licensee's policy to promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act. Policy #AM-6.9 references the Investigation Procedure policy, #AM-6.3 and further to this, the Reporting of Abuse policy, #AM-6.7.

Inspector #148 reviewed the three policies identified above. The policies describe the home's internal process of immediately reporting incidents to the Ministry of Health and Long Term Care including the Mandatory Critical Incident System, Centralized Intake, Assessment and Triage Team and use of after-hours pager system.

As per policy AM #6.9, "Any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based on the Home's Administrator or appropriate designate.

The policy to promote zero tolerance of abuse and neglect of residents does not include an explanation of the duty under section 24, for all persons, to make mandatory reports to the Director, as defined by section 2 (1) of the Act. [s. 20. (2)]

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 did not ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with O.Reg. 79/10, section 2, emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

On a specified date, PSW #S102 witnessed two incidents; one involving the care provided to Resident #1 by PSW #S101 and a second involving the care provided to Resident #2 by PSW #S101. While providing dressing and continence care to Resident #1, PSW #S101 was witness to push and shove the resident roughly. The resident became upset and indicated that he/she was being hurt, the resident was re-visited by PSW #S102 moments later and was still crying over the incident. While providing transfer assistance to Resident #2, the resident indicated that his/her right shoulder was in tremendous pain and that he/she was being hurt and asked to be lowered. PSW #S101 was witnessed to ignore the residents' complaints and told the resident, that he/she

would have to wait until the transfer was complete. PSW #S102 reported that the right side of the sling, located on the side in which PSW #S101 was responsible, was not under the armpit but rather under the arm folds.

Two days after the incidents, PSW #S102 reported information to PSW #S103, through text message, about the incident involving Resident #1, that would be considered reasonable grounds to suspect abuse. PSW #S102 also reported information to the home's Office Manager about the incident involving Resident #1 that may also have been reasonable grounds to suspect abuse. Both PSW #S103 and the Office Manager encouraged PSW #S102 to bring the information forward to the home's DOC.

PSW #S102 informed the DOC of the two witnessed incidents five days after the incidents, at which time the DOC initiated an investigation.

Twenty-seven days after the incident, a family member of Resident #1 approached the Administrator and DOC about information obtained while in the community about an alleged incident of abuse involving Resident #1 and PSW #S101. On a specified date, the family member of Resident #1 contacted the Director, through means of the ActionLine, and reported information of a suspected abuse involving Resident #1.

After having received the information from the ActionLine, Inspector #138, phoned the home's Administrator with respect to the information provided by the family member of Resident #1. On the same date, thirty days after the incident and after the call from Inspector #138, the home's DOC spoke with a representative from OMNI Home Office and submitted a Critical Incident Report to the Director (Ministry of Health and Long Term Care) related to the incident involving Resident #1. The DOC confirmed that no other manner of report was made to the Director until this time. The incident involving Resident #2 was discovered by Inspector #148 during this complaint inspection, prior to the Inspector's arrival to the home on November 25, 2014, no person had reported the incident involving Resident #2, to the Director. [s. 24. (1)]

WN #4: 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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee did not ensure that all staff of the home have received training in the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities and annually thereafter.

In accordance with LTCHA 2007, section 76 (1), (2) and (4) and O.Reg. 79/10 section 219 (1), all staff are to be provided training on the long term care home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities and annually thereafter.

As identified by the home's Administrator, the policy titled Zero Tolerance of Abuse and Neglect of Residents, #AM-6.9, effective September 2013 is the licensee's policy to promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act. Policy #AM-6.9 references the Investigation Procedure policy, #AM-6.3 and further to this, the Reporting of Abuse policy, #AM-6.7.

PSW #S101 returned to work after an extended period off work. PSW #S101 reported to Inspector #148, that he/she could not recall the last time in which training was provided on the long term care home's policy to promote zero tolerance of abuse and neglect of residents. The home could not demonstrate that PSW #S101 had been provided with training on the long term care home's policy to promote zero tolerance of abuse and neglect of residents, within the last year or prior to performing responsibilities upon returning to work in August 2014. [s. 76. (4)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the resident's substitute decision-maker (SDM) was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident. In addition, the licensee did not ensure that the resident's SDM was notified of the results of the investigation required under subsection 23 (1) of the Act.

In accordance with O.Reg. 79/10, section 2, emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

On a specified date, PSW #S102 witnessed two incidents; one involving the care provided to Resident #1 by PSW #S101 and a second involving the care provided to Resident #2 by PSW #S101. While providing dressing and continence care to Resident #1, PSW #S101 was witness to push and shove the resident roughly. The resident became upset and indicated that he/she was being hurt, the resident was re-visited by PSW #S102 moments later and was still crying over the incident. While providing transfer assistance to Resident #2, the resident indicated that his/her right shoulder was in tremendous pain and that he/she was being hurt and asked to be lowered. PSW #S101

was witnessed to ignore the residents' complaints and told the resident, that he/she would have to wait until the transfer was complete. PSW #S102 reported that the right side of the sling, located on the side in which PSW #S101 was responsible, was not under the armpit but rather under the arm folds.

Five days after the incidents, PSW #S102 informed the DOC of the two witnessed incidents, at which time the DOC initiated an investigation. The DOC reported to Inspector #148 that the investigation had concluded prior to the approach by the family member of Resident #1, described below.

Twenty-seven days after the incident, a family member of Resident #1 approached the Administrator and DOC about information obtained while in the community about an incident of alleged abuse involving Resident #1. The day after, the primary substituted decision maker (SDM) of Resident #1 also approached the DOC, acknowledging that the SDM(s) of Resident #1 had not been informed by the Administrator or DOC, of any alleged abuse involving Resident #1. Inspector #148 spoke with the SDM of Resident #1 who indicated that no notification had been given, by the Administrator or DOC, of the alleged incident or that the home had initiated, conducted and concluded an investigation related to the incident.

Inspector #148 spoke with the SDM of Resident #2. The SDM of Resident #2 indicated that at the time of the inspector's interview, no notification had been provided of the alleged incident of abuse involving Resident #2 or that the home had initiated, conducted and concluded an investigation related to the alleged incident.

Inspector #148 spoke with the home's Administrator and DOC, who both confirmed that neither SDM(s) for Resident #1 or Resident #2, had been notified as required, of the alleged incidents of abuse involving PSW #S101. The DOC indicated that SDM(s) were not informed of the home's initiation of an investigation or the conclusions of the investigation, given that the abuse was alleged and that the home concluded that there was insufficient evidence to support abuse occurred. [s. 97. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a report to the Director, under section 23(2) of the Act, included the location of the incident and names of any staff member or other persons who were present at or discovered the incident.

In accordance with LTCHA 2007, s.23(1)(b) and s.23(2), the licensee shall report to the Director the results of every investigation undertaken for every alleged suspected or witnessed incident of abuse of a resident by anyone, and every action taken in response to such an incident. Further to this O.Regulation 79/10, s.104(1), describes the contents of the written report required by section 23(2).

On a specified date, PSW #S102 witnessed two incidents; one involving the care provided to Resident #1 by PSW #S101 and a second involving the care provided to Resident #2 by PSW #S101. While providing dressing and continence care to Resident #1, PSW #S101 was witness to push and shove the resident roughly. The resident became upset and indicated that he/she was being hurt, the resident was re-visited by PSW #S102 moments later and was still crying over the incident. While providing transfer assistance to Resident #2, the resident indicated that his/her right shoulder was in tremendous pain and that he/she was being hurt and asked to be lowered. PSW #S101 was witnessed to ignore the residents' complaints and told the resident, that he/she

would have to wait until the transfer was complete. PSW #S102 reported that the right side of the sling, located on the side in which PSW #S101 was responsible, was not under the armpit but rather under the arm folds. Resident #1 was not able to recall the incident. Resident #2 reported to the DOC, during the investigation, that his/her arm was sore for a day or two after the incident.

Five days after the incidents, PSW #S102 informed the DOC of the two witnessed incidents, at which time the DOC initiated an investigation which included interviews with PSW #S101 and PSW #S102 and Residents #1 and #2, health care record reviews and a review of PSW #S101 employee file.

Thirty days after the incident the home's DOC submitted a Critical Incident Report (CIR) describing the alleged incident of abuse involving Resident #1. The CIR represents the only written report to the Director received, related to the alleged incident of abuse of Resident #1.

Inspector #148 reviewed the CIR and it was demonstrated that the written report does not indicate the name of PSW #S101 and did not describe the area or location of the incident. [s. 104. (1) 2.]

2. The licensee has failed to ensure that a report to the Director, under section 23(2) of the Act, is made within 10 days of becoming aware of the alleged, suspected or witnessed incident.

Information required under O.Reg 79/10 s.104(1) was available within 10 days of the DOC becoming aware of the alleged incident of abuse, however, the written report provided to the Director was not within 10 days of becoming aware of the alleged incident of abuse. Twenty three business days passed prior to the licensee submitting a written report to the Director. [s. 104. (2)]

Issued on this 8th day of January, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148)
Inspection No. / No de l'inspection :	2014_200148_0041
Log No. / Registre no:	O-000782-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 5, 2015
Licensee / Titulaire de permis :	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9
LTC Home / Foyer de SLD :	WOODLAND VILLA 30 Milles Roches Road, R. R. #1, Long Sault, ON, K0C-1P0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MICHAEL RASENBERG

To OMNI HEALTH CARE LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 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 allegations of resident abuse and neglect are reported and investigated in accordance with the legislated requirements.

The licensee shall submit a written plan that, at minimum, includes:

- A revision of the policy to promote zero tolerance of abuse and neglect of residents to include an explanation of the duty under section 24 to make mandatory reports;
- Education of all staff related to the revised policy to promote zero tolerance of abuse and neglect of residents;
- A process to audit each investigation into allegations of resident abuse and neglect to ensure compliance with the legislation. Additionally, the home will develop a written plan of corrective action to address any failures identified.

The plan shall be submitted in writing to Inspector Amanda Nixon by fax #613-569-9670, no later than January 14, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the home protected Resident #1 and #2 from abuse by anyone.

In accordance with O.Reg. 79/10, section 2, emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

As demonstrated by this inspection report the home failed to protect residents from abuse in that:

The Administrator and DOC did not follow the policy to promote zero tolerance of abuse and neglect of residents, as indicated by WN #2. This notification indicates that reporting procedures, including reporting to the Director, OMNI Home Office and resident substitute decision makers (SDMs) were not followed. In addition, procedures describing the removal of an employee alleged to have committed an abusive act from the work environment was not followed. Further to this, the lead for the home's investigation, identified as the home's DOC, was unfamiliar with the home's policy to promote zero tolerance of abuse and neglect of residents and related investigative and reporting policies.

The home's policy does not provide for a clear explanation of the duty under s.24 to make mandatory reports, as indicated by WN #2. This inspection demonstrates that staff members and managers had information related to the alleged incident of abuse involving Resident #1, however, a report of the alleged abuse was not provided to the Director until 35 days after the alleged incident, as noted in WN #3. In addition, with the exception of Inspector #148's discovery of the incident involving Resident #2, no person had made a report to the Director prior to November 25, 2014, related to the incident involving Resident #2.

Notification was not provided, as required, to the resident's SDM(s), related to the alleged incidents of abuse or the conclusions of the investigation, as indicated by WN #5. In addition, after the home was approached by family members of Resident #1, neither, the Administrator or DOC made contact with the SDM of Resident #2, as of December 5, 2014. The DOC indicated that the SDMs were not informed of the investigation as the incident was alleged and the investigation concluded insufficient evidence to support abuse occurred.

The home did not put in place interventions to ensure that Resident #1 and Resident #2 were protected from abuse pending the investigation.

The DOC acknowledges the delay of reporting by PSW #S102 and the known

care issues with PSW #S101, however, cannot demonstrate that any action was taken with respect to re-education for either staff member. Further, the home cannot demonstrate that PSW #S101 has been provided education on the policy to promote zero tolerance of abuse and neglect of residents within the last year or upon return from an extend leave of absence, as per WN #4.

The Administrator and DOC failed to follow up with all leads of information including potential information held by PSW #S103 related to the incident of alleged abuse of Resident #1. When followed up by Inspector #148, the information held by PSW #103 lead to another staff member with potential information about the alleged incident of abuse of Resident #1, of which the home was not aware.

In addition, the home concluded insufficient evidence existed to support that abuse occurred, despite the history of care complaints related to PSW #S101 and that both incidents were witnessed by a credible witness, as described by the DOC.

On a specified date, PSW #S102 witnessed two incidents; one involving the care provided to Resident #1 by PSW #S101 and a second involving the care provided to Resident #2 by PSW #S101. While providing dressing and continence care to Resident #1, PSW #S101 was witness to push and shove the resident roughly. The resident became upset and indicated that he/she was being hurt, the resident was re-visited by PSW #S102 moments later and was still crying over the incident. While providing transfer assistance to Resident #2, the resident indicated that his/her right shoulder was in tremendous pain and that he/she was being hurt and asked to be lowered. PSW #S101 was witnessed to ignore the residents' complaints and told the resident, that he/she would have to wait until the transfer was complete. PSW #S102 reported that the right side of the sling, located on the side in which PSW #S101 was responsible, was not under the armpit but rather under the arm folds. Resident #1 was not able to recall the incident. Resident #2 reported to the DOC, during the investigation, that his/her arm was sore for a day or two after the incident.

Two days after the incidents, PSW #S102 reported information to PSW #S103, through text message, about the incident involving Resident #1, that would be considered reasonable grounds to suspect abuse. PSW #S102 also reported information to the home's Office Manager about the incident involving Resident #1 that may also have been reasonable grounds to suspect abuse. PSW #S102

left a voice message with the home's DOC, without indicating specific information about either incident. The DOC returned the call and on the same date met with PSW #S102 at which time witness reports were completed describing both incidents involving Resident #1 and #2 and staff member PSW #S101.

The DOC initiated an investigation which included interviews with PSW #S101 and PSW #S102 and Residents #1 and #2, health care record reviews and a review of PSW #S101 employee file. Staffing schedules and an interview with PSW #S101, indicate that PSW #S101 continued to work with Resident #1 and #2 during the time frame of the investigation. The DOC confirmed no measures were put in place to ensure the safety of Resident #1 and #2 pending the investigation. The Administrator and DOC acknowledged that PSW #S101 has a history of complaints related to resident care from family, staff and residents. The DOC reported to Inspector #148, that PSW #S102 was considered a credible witness with no reason to provide false information. The investigation concluded there to be insufficient evidence to support abuse had occurred in either case involving Resident #1 and Resident #2. It was further reported by the DOC, that although they could not substantiate that abuse had occurred, that re-education to PSW #S101 and PSW #S102 was provided. The home could not demonstrate that this re-education had occurred; PSW #S101 could not recall having been provided re-education regarding the described alleged incidents of abuse.

Twenty-seven days after the incident, a family member of Resident #1 approached the Administrator and DOC about information obtained while in the community about an incident of alleged abuse involving Resident #1. During this meeting the family member requested that PSW #S101 be removed from the care of Resident #1, the home implemented this request on the same date. The day after the primary substituted decision maker (SDM) of Resident #1 also approached the DOC, acknowledging that the SDM(s) of Resident #1 had not been informed by the Administrator or DOC, of any alleged abuse involving Resident #1. Inspector #148 spoke with the SDM of Resident #1 who indicated that no notification had been given, by the Administrator or DOC, of the alleged incident or that the home had initiated, conducted and concluded an investigation related to the incident.

Inspector #148 spoke with the SDM of Resident #2. The SDM of Resident #2 indicated that at the time of the inspector's interview, no notification had been

provided of the alleged incident of abuse involving Resident #2 or that the home had initiated, conducted and concluded an investigation related to the alleged incident.

In addition, the SDM of Resident #1 informed the DOC that PSW #S103 had information pertaining to the alleged incident involving Resident #1. The Administrator acknowledged to Inspector #148, that he was aware of this information. The DOC confirmed with Inspector #148, on November 26, 2014, that PSW #S103 had not been spoken to as part of the home's investigation.

On a specified date, the family member of Resident #1 contacted the Director, through means of the ActionLine, and reported information of a suspected abuse involving Resident #1.

After having received the information from the ActionLine, Inspector #138, phoned the home's Administrator with respect to the information provided by the family member of Resident #1. On the same date, after the call from Inspector #138, the home's DOC spoke with a representative from OMNI Home Office and submitted a Critical Incident Report to the Director (Ministry of Health and Long Term Care) related to the incident involving Resident #1. The DOC confirmed that no other manner of report was made to the Director, related to the incidents of alleged abuse of Resident #1, until 30 days after the incident was reported to the DOC.

The incident involving Resident #2 was discovered by Inspector #148 during this complaint inspection. It was confirmed with the DOC, that prior to Inspector #148's arrival to the home on November 25, 2014, no person had reported the incident involving Resident #2, to the Director. [s. 19. (1)]
(148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2015

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON

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