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

Division de la responsabilisation et de la performance du système de santé
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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
Apr 22, 2015	2015_414110_0004	T-1773-15	Resident Quality Inspection

Licensee/Titulaire de permis

WOODS PARK CARE CENTRE INC.
110 LILLIAN CRESCENT BARRIE ON L4N 5H7

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

WOODS PARK CARE CENTRE
110 LILLIAN CRESCENT BARRIE ON L4N 5H7

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

DIANE BROWN (110), VALERIE JOHNSTON (202), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 12,13, 16,17, 18, 19, 20, 23, 24, 26, 27, 30, 31, April 1 and 2, 2015.

During the course of the inspection the following intakes were inspected concurrently:
T-1554-14 follow-up to order, T-1472-14 critical incident, T-1603-14 complaint, T-2061-15 complaint.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC, associate director of care (ADOC), registered dietitian (RD), registered nursing staff, food service manager, resident care coordinator (RCC), dietary aide, nursing preceptor, nursing student, personal support workers (PSW's), families, residents, volunteers

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Training and Orientation

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

11 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 221. (2)	CO #002	2014_159178_0019	110

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 :

1. The licensee has failed to ensure that all residents are protected from verbal and emotional abuse by anyone.

The home's Abuse and Neglect of a Resident-Actual or Suspected policy, revised April 2013, defines emotional and verbal abuse as "any verbal or non-verbal behaviour which demonstrates disrespect for the resident and which is perceived by the resident, the nurse or others to be emotionally abusive. Such verbal and non-verbal behaviours include, but are not limited to:
Any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident".

On an identified date, an identified family member reported to the DOC that he/she witnessed an identified PSW, PSW #01, speaking and acting inappropriately with residents in the dining room. An interview with the DOC indicated that the family member witnessed PSW #01 act and speak to residents in a verbally inappropriate manner on four identified dates.
An interview with the identified family member confirmed witnessing PSW #01 act and speak to residents in a verbally inappropriate manner and indicated that the PSW had also been witnessed holding spoons of food in front of residents and pulling the spoon back when they are prompted to eat and withholding coffee and fluids from residents if they do not complete their meal.
On an identified date shortly after the date of the report received from the family member, an identified RPN student and an identified preceptor, reported to the ADOC that they had concerns regarding PSW #01. An interview with the ADOC indicated that both the student and preceptor expressed concerns regarding this identified PSW. The ADOC indicated that the student had witnessed PSW #01 inappropriately interact with residents on many occasions and felt it was time to report as the issues were keeping him/her awake at night.
An interview with the student indicated that he/she had been assigned to observe PSW #01 as part of his/her training, one day per week during semester one and two days per week during semester two. The student indicated that PSW #01 had been inappropriate on several occasions during his/her training. The student indicated that PSW #01 had been rude and rough with resident's causing them to be humiliated. The student indicated that during the first semester of training he/she witnessed PSW #01 roughly care for a resident in bed. The student further indicated that he/she witnessed the identified PSW withhold coffee from residents who did not finish their meal and witnessed the PSW physically restrain a resident. The student indicated that the above incidents had been shared with his/her preceptor at the daily debriefing sessions. Both the student and the preceptor indicated in interviews that they had been reluctant to report the above incidents of abuse as they believed they did not have enough witnessed incidents to file

a report.

An interview with a front line staff member indicated that he/she had witnessed PSW #01 treat residents like children, threatening them to not receive an item unless they finish their meal. The front line staff member indicated in an interview that the PSW had mannerisms that were inappropriate, however, was unable to report the above allegations as he/she feared reprisal from his/her colleagues and managers of the home.

An interview with the DOC indicated that upon receipt of the allegations brought forward by the family member and the student an investigation commenced. The DOC confirmed that as a result of the investigation PSW #01 had been responsible for verbal and emotional abuse toward residents. The identified PSW received a two day suspension, abuse education and was relocated to another home area within the home. [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 O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are standardized recipes and production sheets for all menus.
Resident #30 required a specialized diet related to his/her diagnosis. Record review revealed that on resident's admission, the physicians order and resident's plan of care required resident #30 to have a specialized diet.
Months later, resident #30 was provided soup at lunch that was not palatable and could not be eaten. An interview with the resident, by inspector #202, revealed that there is never a day that the food is good. The food service manager tasted the soup and confirmed to inspector #202 and the resident that the soup was not palatable. Recipe review and an interview with the cook and food service manager confirmed there are no standardized recipes to support the specialized diet the resident requires. [s. 72. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there are standardized recipes and production sheets for all menus, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques used to assist residents with eating, including safe positioning of residents who require assistance.

On an identified date, at lunch, resident #16 was observed being fed by a staff member. A pattern of feeding was observed, whereby resident #16's head would fall forward and the staff assisting would push the resident's head up and hold resident's head up with the palm of his/her hand on the resident's forehead while feeding resident. There was no communication directed towards the resident during the head positioning process. Interviews with both a registered staff supervising the dining room and the registered dietitian confirmed that this was not a respectful approach to feeding resident #16. The registered dietitian identified that he/she had dealt with this issue approximately one year ago and that resident would require a wheelchair assessment for proper positioning at meals. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that proper techniques used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee has fully respected and promoted the resident's right to have his or her lifestyle and choices respected.
Resident #03 has not been provided his/her bathing preference of two bathes per week. Resident #03 responded, when asked by a Ministry inspector during stage 1 interviews, that he/she doesn't have his/her bathing preference of two baths per week but has a shower and a bath. Resident stated that he/she would prefer two baths if staff have time, but that the staff are very busy. A staff interview revealed awareness that the resident prefers to have baths and looks forward to having bath. Record review revealed that the written plan of care stated to provide the resident with two showers per week. Bathing records revealed that on three recent occasions, the resident was provided a shower and not his/her preferred choice of a bath. [s. 3. (1) 19.]

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
On an identified date, at lunch, resident #16 was observed being fed. A pattern of feeding was observed whereby the resident's head would fall forward and staff would push the

resident's head up and hold resident's head up with the palm of his/her hand on the residents forehead while feeding the resident. The registered staff and registered dietitian confirmed that this was not a respectful approach to feeding resident #16.
An interview and record review revealed that the registered dietitian was aware that the resident remains difficult to feed related to positioning in chair and head droop.
The plan of care identifies that staff are to ensure that resident #16 is as upright as possible for all oral intake.
The plan of care does not provide clear direction to staff on how to ensure a safe and respectful resident position while providing total feeding assistance. [s. 6. (1) (c)]

2. The licensee has failed to ensure that plan of care based on an assessment of the resident and the resident's needs and preferences.
Resident #07 was admitted four years ago, and was identified with impaired vision as the resident no longer wore glasses related to pain. At the admission care conference, it was identified that the resident had used a magnifying glass for small print.

The admission plan of care identified an intervention to obtain an eye exam consultation for resident to ensure appropriate medications and compensatory mechanism as resident does not wear glasses. A resident interview confirmed he/she was unable to read small print but can read large print.

Record review and an interview with the DOC confirmed that the resident's vision had not been assessed on admission and for several years including resident's need for a magnifying glass. [s. 6. (2)]

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

Resident #29's written plan of care directs registered staff to change his/her continence care appliance monthly. A review of the resident's clinical records indicated that the resident had his/her appliance changed in month A, and again in month C. A review of the resident's clinical records indicated that the resident was required to have his/her continence care appliance changed in month B. Staff interviews and record review confirmed that the resident did not have his/her appliance changed at any time during month B. Staff confirmed that the resident had not been provided the care as specified in the resident's plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care is provided to

the resident as specified in the plan.

Resident #07 was admitted on an identified date three years ago and assessed with impaired vision as the resident no longer wears glasses related to pain.

The admission plan of care identified an intervention to obtain an eye exam consultation for resident to ensure appropriate medications and compensatory mechanism as the resident does not wear glasses.

On an identified date during the inspection resident #07 was observed with a magazine in hand and confirmed that he/she was unable to read the small print but could read large print.

Record review and an interview with the DOC confirmed that the resident's plan of care related to obtaining an eye exam consultation had not been completed from resident's admission for 2.5 years and that staff did not follow the plan of care. [s. 6. (7)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Pain and Symptom-Assessment and Management Protocol policy, dated February 2013 is complied with.

The home's Pain and Symptom-Assessment and Management Protocol policy, dated February 2013, directs registered staff to conduct and document a pain assessment on initiation of a pain medication or PRN analgesic. A review of resident #27's clinical records indicated that on an identified date, the physician ordered the resident to be administered a medication every four to six hours as necessary (PRN) for increased pain. A review of the resident's clinical records indicated that the resident had been assessed for pain during his/her admission, with no further pain assessment identified. An interview with the RCC confirmed that the resident had not been assessed for pain by registered staff upon initiation of the prescribed PRN analgesic as in accordance to the above mentioned policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Abuse and Neglect of a Resident-Actual or Suspected, revised April 2013, contains an explanation of the duty under section 24 to make mandatory reports.

A review of the home's Abuse and Neglect of a Resident-Actual or Suspected, revised April 2013, states, all complaints (verbal or written) from residents, families, visitors and staff that concern a reportable matter as set out in Section 24 of the Long Term Care Act, 2007, shall be immediately reported and investigated. The abuse checklist attachment (b) to this policy will be used to ensure all parties are contacted immediately. A review of the checklist attachment (b) indicated that it is the responsibility of the DOC/Administrator to update the Ministry of Health and Long Term Care Director.

An interview with the RCC confirmed that the above mentioned policy does not contain a full explanation of the duty under section 24 to make mandatory reports as follows:

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 or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2). [s. 20. (2)]

WN #8: 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 failed ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk to harm to the resident is immediately reported to the Director.

On an identified date, an identified family member reported to the DOC that he/she witnessed an identified PSW, PSW #01, speaking and acting inappropriately with residents in the dining room. An interview with the DOC indicated that the family member witnessed PSW #01 act and speak to residents in a verbally inappropriate manner on four identified dates.

An interview with an identified RPN indicated that both the student and the preceptor reported the above allegations to him/her and asked that the student and the preceptor report to the ADOC. An interview with the ADOC indicated that both the student and the preceptor reported the above allegations to her and indicated that she then reported these allegations to the DOC.

An interview with a front line staff member indicated that he/she had witnessed PSW #01 treat residents like children, threatening them to not receive an item unless they finish their meal. The front line staff member indicated in an interview that the PSW had mannerisms that were inappropriate, however, was unable to report the above allegations as he/she feared reprisal from his/her colleagues and managers of the home.

An interview with the DOC indicated that upon receipt of the allegations brought forward by the family member and the student an investigation commenced. The DOC confirmed that as a result of the investigation PSW #01 had been responsible for verbal and emotional abuse toward residents. The identified PSW received a two day suspension, abuse education and was relocated to another home area within the home

A review of the home's Abuse and Neglect of a Resident-Actual or Suspected, revised April 2013, states, all complaints (verbal or written) from residents, families, visitors and staff that concern a reportable matter as set out in Section 24 of the Long Term Care Act, 2007, shall be immediately reported and investigated. The abuse checklist attachment (b) to this policy will be used to ensure all parties are contacted immediately. A review of the checklist attachment (b) indicated that it is the responsibility of the DOC/Administrator to update the Ministry of Health and Long Term Care Director.
Staff interviews indicated that they have been directed to report any reported, witnessed, or suspected abuse to their charge nurse or manager. Staff had no awareness of the duty to make mandatory reports under section 24 of the LTCHA, 2007, to the Director.
An interview with the RCC confirmed that staff are educated on the home's above mentioned policy which directs staff to report any reported, witnessed or suspected abuse to their charge nurse or manager. The RCC indicated, however, that she will educate staff verbally during orientation that anyone can call the Director in regards to mandatory reporting and refers staff to follow the signage posted in the home. [s. 24. (1)]

WN #9: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that residents plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident.
Resident #09 responded, when asked by a Ministry inspector, during stage 1 interviews, that he/she does not have a choice of when to get up in the morning and that he/she would like to sleep in. Record review identified that resident #09's plan of care identified that resident #09 prefers to get up at 0700 hrs and that the resident will determine if he/she wants to sleep later.
An interview with a PSW revealed that resident #09 does have to be woken up in the morning and that he/she required a two person mechanical lift. The PSW stated that those residents requiring a two person mechanical lift are first to get up. The PSW confirmed that he/she does not offer the resident a choice if he/she would like to continue to sleep. [s. 26. (3) 21.]

WN #10: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to resident, prior to performing their responsibilities.

Direct care staff interviews indicated no awareness of the duty to make mandatory reports under section 24 of the LTCHA, 2007. An interview with the RCC/staff educator confirmed that all staff and students receive training upon hire and annually on the home's abuse policy. A review of the home's Abuse and Neglect of a Resident-Actual or Suspected, revised April 2013, states, all complaints (verbal or written) from residents, families, visitors and staff that concern a reportable matter as set out in Section 24 of the Long Term Care Act, 2007, shall be immediately reported and investigated. The abuse checklist attachment (b) to this policy will be used to ensure all parties are contacted immediately. A review of the checklist attachment (b) indicated that it is the responsibility of the DOC/Administrator to update the Ministry of Health and Long Term Care Director. The RCC indicated that staff are directed to follow the directions in the home's abuse policy, however, she has verbally educated staff during orientation that anyone can call the Director of a reportable matter and refers staff to follow the ministry of health and long-term care signage posted in the home. [s. 76. (2) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

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 identifies the training and retraining requirements for all staff including the training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

The home's Abuse and Neglect of a Resident-Actual or Suspected, Policy #VI-G-10.00 revised, April 2013, does not identify the training and retraining requirements for all staff including the training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. An interview with the Administrator confirmed the above. [s. 96. (e)]

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

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Issued on this 25th day of April, 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) :	DIANE BROWN (110), VALERIE JOHNSTON (202), VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2015_414110_0004
Log No. / Registre no:	T-1773-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 22, 2015
Licensee / Titulaire de permis :	WOODS PARK CARE CENTRE INC. 110 LILLIAN CRESCENT, BARRIE, ON, L4N-5H7
LTC Home / Foyer de SLD :	WOODS PARK CARE CENTRE 110 LILLIAN CRESCENT, BARRIE, ON, L4N-5H7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHY COTTON

To WOODS PARK CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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:

a) Provide a plan to the inspector identifying how the home shall protect all residents from abuse by anyone.

b) Amend the licensee's policy to promote zero tolerance of abuse and neglect of residents to ensure it provides all of the requirements in s. 20(2) of the LTCHA, including 20 (2)(d) in that it shall contain an explanation of the duty under section 24 to make mandatory reports;

c) Provide a plan to the inspector, identifying when all staff, volunteers and students within the home will receive training on any changes to the licensee's policy to promote zero tolerance of abuse and neglect of residents, including the duty under section 24 to make mandatory reports.

The plans (a) and (c) shall be submitted to Valerie.johnston@ontario.ca by May 20, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents are protected from verbal and emotional abuse by anyone.
The home's Abuse and Neglect of a Resident-Actual or Suspected policy, revised April 2013, defines emotional and verbal abuse as "any verbal or non-verbal behaviour which demonstrates disrespect for the resident and which is perceived by the resident, the nurse or others to be emotionally abusive. Such verbal and non-verbal behaviours include, but are not limited to:
Any threatening, insulting, intimidating or humiliating gestures, actions,

behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident".

On an identified date, an identified family member reported to the DOC that he/she witnessed an identified PSW, PSW #01, speaking and acting inappropriately with residents in the dining room. An interview with the DOC indicated that the family member witnessed PSW #01 act and speak to residents in a verbally inappropriate manner on four identified dates.

An interview with the identified family member confirmed witnessing PSW #01 act and speak to residents in a verbally inappropriate manner and indicated that the PSW had also been witnessed holding spoons of food in front of residents and pulling the spoon back when they are prompted to eat and withholding coffee and fluids from residents if they do not complete their meal.

On an identified date a few days after the date of the report received from the family member, an identified RPN student and an identified preceptor, reported to the ADOC that they had concerns regarding PSW #01. An interview with the ADOC indicated that both the student and preceptor expressed concerns regarding this identified PSW. The ADOC indicated that the student had witnessed PSW #01 inappropriately interact with residents on many occasions and felt it was time to report as the issues were keeping him/her awake at night.

An interview with the student indicated that he/she had been assigned to observe PSW #01 as part of his/her training, one day per week during semester one and two days per week during semester two. The student indicated that PSW #01 had been inappropriate on several occasions during his/her training. The student indicated that PSW #01 had been rude and rough with resident's causing them to be humiliated. The student indicated that during the first semester of training he/she witnessed PSW #01 roughly care for a resident in bed. The student further indicated that he/she witnessed the identified PSW withhold coffee from residents who did not finish their meal and witnessed the PSW physically restrain a resident. The student indicated that the above incidents had been shared with his/her preceptor at the daily debriefing sessions. Both the student and the preceptor indicated in interviews that they had been reluctant to report the above incidents of abuse as they believed they did not have enough witnessed incidents to file a report.

An interview with a front line staff member indicated that he/she had witnessed PSW #01 treat residents like children, threatening them to not receive an item unless they finish their meal. The front line staff member indicated in an interview that the PSW had mannerisms that were inappropriate, however, was

unable to report the above allegations as he/she feared reprisal from his/her colleagues and managers of the home.

An interview with the DOC indicated that upon receipt of the allegations brought forward by the family member and the student an investigation commenced. The DOC confirmed that as a result of the investigation PSW #01 had been responsible for verbal and emotional abuse toward residents. The identified PSW received a two day suspension, abuse education and was relocated to another home area within the home. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 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 22nd day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

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