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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 5, 2021	2020_520622_0024	024717-20	Complaint

Licensee/Titulaire de permis

Kemptville District Hospital
2675 Concession Road P.O. Bag 2007 Kemptville ON K0G 1J0

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

Kemptville District Hospital
2675 Concession Road P.O. Bag 2007 Kemptville ON K0G 1J0

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

HEATH HEFFERNAN (622)

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): December 16, 17, 18, 2020

The following intake was completed in this complaint inspection:

Log #022733-20 related to a review of the incident reporting structure and complaint process.

During the course of the inspection, the inspector(s) spoke with the VP Nursing/Clinical Services, CNE (Administrator), the Manager of Nursing Services (Director of Care), the Registered Nurse (RN) Nursing Team Lead, the Human Resources Officer, Registered Practical Nurse (RPNs) and the residents.

Also during the course of the inspection, the inspector reviewed resident health records, applicable licensee policies and procedures and training records.

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

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

3 WN(s)
1 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure that the VP Nursing/Clinical Services, CNE, the Manager of Nursing Services, and the Nursing Team Lead have received annual retraining specific to the licensee’s policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports.

On December 16, 2020, the VP Nursing/Clinical Services, CNE and the Manager of Nursing Services were not able to correctly answer questions related to the time frame for the reporting of mandatory reports.

On December 17, 2020, inspector reviewed the Surge Learning course completion list for the licensee’s zero tolerance of abuse and neglect of residents, Policy Number: VII-6B - Prevention and Management of ILTC Resident abuse and neglect, dated March 2015. The completion list included all front-line staff who work on the Long-Term Care Unit. 25 of the 33 staff were documented as completing the retraining between January 1, 2020 to December 16, 2020. The list did not include the VP Nursing/Clinical Services, CNE, The Manager of Nursing Services or the Nursing Team Lead.

Therefore, the licensee failed to ensure that the VP Nursing /Clinical services, CNE, Manager of Nursing Services, and the Nursing Team Lead received annual retraining specific to the licensee’s policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports.

Sources: review of the licensee’s related policy, the related staff completion documentation, interview of the VP Nursing /Clinical services, CNE and others. [s. 76. (4)]

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect physical abuse of resident #002 by resident #003 that resulted in harm or a risk of harm to the resident was reported immediately to the Director.

On a date in April 2020, resident #003 was observed to be in a physical and verbal altercation with resident #002, during which time resident #002 sustained an injury.

A review of the Ministry of Long-Term Care, Critical Incident reporting website indicated that there were no critical incidents reported by the Kemptville District Hospital Long-Term Care unit in the past year. The progress notes and the Risk Incident Management System (RIMs) reports dated did not state that the Ministry of Long-Term Care were notified related to the incident of resident #003 to resident #002 physical abuse and the VP Nursing/Clinical Services, CNE stated that the Ministry of Long-Term Care was not notified for the incident.

Sources: review of the applicable resident health records, the Risk Incident Management System (RIMs) reports, interview with the VP Nursing/Clinical Services, CNE and others. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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:

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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received a response indicating the outcome of the investigation or what was done to resolve a verbal complaint of care and services they made to a Registered Practical Nurse (RPN).

Resident #001 was noted by the RPN to be anxious and had concerns related to two staff picking on them and the care they had not received.

On December 16, 2020, the Manager of Nursing Services and the Nursing Team Lead stated that after the investigation related to resident #001's verbal complaint was completed, they did not make any response to resident #001 related to what was done to resolve the situation or the outcome of the investigation.

Sources: Review of health records and interview with the Manager of Nursing, resident #001, the RPN and other staff. [s. 101. (1) 3.]

Issued on this 12th day of January, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HEATH HEFFERNAN (622)
Inspection No. / No de l'inspection :	2020_520622_0024
Log No. / No de registre :	024717-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 5, 2021
Licensee / Titulaire de permis :	Kemptville District Hospital 2675 Concession Road, P.O. Bag 2007, Kemptville, ON, K0G-1J0
LTC Home / Foyer de SLD :	Kemptville District Hospital 2675 Concession Road, P.O. Bag 2007, Kemptville, ON, K0G-1J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy Burke

To Kemptville District Hospital, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 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. 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).

Order / Ordre :

The licensee must be complainant with s. 76 (4). of the LTCHA,

by ensuring that the VP Nursing/Clinical Services #100, the Manager of Nursing Services #101, the Nursing Team Lead #102 and all other staff receive annual retraining specific to:

The Licensee's policy to promote zero tolerance of abuse and neglect of residents.
The duty under section 24 to make mandatory reports.

and a documented record of the training must be kept.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the VP Nursing/Clinical Services, CNE, the Manager of Nursing Services, and the Nursing Team Lead have received annual retraining specific to the licensee's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports.

On December 16, 2020, the VP Nursing/Clinical Services, CNE and the Manager of Nursing Services were not able to correctly answer questions related to the time frame for the reporting of mandatory reports.

On December 17, 2020, inspector reviewed the Surge Learning course completion list for the licensee's zero tolerance of abuse and neglect of residents, Policy Number: VII-6B - Prevention and Management of ILTC

Resident abuse and neglect, dated March 2015. The completion list included all front-line staff who work on the Long-Term Care Unit. 25 of the 33 staff were documented as completing the retraining between January 1, 2020 to December 16, 2020. The list did not include the VP Nursing/Clinical Services, CNE, The Manager of Nursing Services or the Nursing Team Lead.

Therefore, the licensee failed to ensure that the VP Nursing /Clinical services, CNE, Manager of Nursing Services, and the Nursing Team Lead received annual retraining specific to the licensee's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports.

Sources: review of the licensee's related policy, the related staff completion documentation, interview of the VP Nursing /Clinical services, CNE and others. [s. 76. (4)]

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

Severity: The VP Nursing /Clinical services, CNE, the Manager of Nursing Services, the Nursing Team Lead had not received training related to the licensee's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports.
There was risk to the residents as three leadership positions for the Long-Term Care Unit at the hospital had not received training related to the licensee's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports. They were not aware of the legislation related to mandatory reporting. They failed to report an incident of abuse between two residents.
Scope: This non-compliance was widespread as the three staff reviewed VP Nursing /Clinical services, CNE, the Manager of Nursing Services, The Nursing Team Lead all missed having training on the licensee's policy.
Compliance History: One written notification (WN) was issued to the licensee related to the same section of the legislation in the past 36 months.

(622)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 16, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of January, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Heath Heffernan

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