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
Direction de l'amélioration de la performance et de la conformité

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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
Aug 6, 2015	2015_333577_0004	S-008713-14 & S-006783-14	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

BETHAMMI NURSING HOME
63 CARRIE STREET THUNDER BAY ON P7A 4J2

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

DEBBIE WARPULA (577)

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): January 7, 8 & 9, 2015

During the course of the inspection, the inspector conducted a tour of resident home areas, observed the provision of care and services to residents, observed interactions between staff members and residents, reviewed health care records of residents, and reviewed policies and procedures

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Nursing Manager, Registered Practical Nurse (RPN), Personal Support Workers (PSW), and Residents

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 VPC(s)**
- **3 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 :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Under O.Reg. 79/10, verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's well-being, dignity or self-worth, that is made by anyone other than a resident". Neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

In October 2014, information was received by the Ministry of Health and Long-Term Care concerning verbal abuse and neglect toward residents by #S-105. Specifically, swearing and yelling at residents, refusing to give residents tub baths, using unsafe resident transfer techniques for residents requiring mechanical lifts, and falsifying charting regarding tub baths. According to the information received, management has been informed of these concerns.

In October 2014, further information was received by the Ministry of Health and Long-Term Care concerning abuse and neglect toward residents by #S-105. Specifically verbal abuse towards residents and refusing to give baths to residents. According to the information received these concerns have been discussed with management and feels nothing is being done. They also indicated that staff are worried about the residents.

In January 2015, Inspector #577 spoke with #S-106, who reported that they have witnessed verbal abuse and neglect toward residents by #S-105. Specifically from July-September 2014, #S-105 was witnessed belittling resident #003 on a daily basis. It was further reported, that on a day in September 2014, Resident #003 was ill and required assistance to get back in to their bed. #S-106 reported that #S-105 refused to help resident and also stated that #S-105 has refused to give residents tub baths from April-October 2014, has witnessed #S-105 neglect to feed residents in dining room and overheard #S-105 call Residents #003, #002 and #006 profane names many times throughout the summer and used profane language. It was further reported that #S-105 has consistently refused to care for Resident #002 and would leave the resident in bed. #S-106 reported that they spoke to the Nurse Manager in June, August and September 2014 about resident abuse and neglect. They reported telling the Nurse Manager that they were reporting this to the Ministry of Health, and was told, "You don't have to go that far, let me deal with it". A meeting was held in November 2014, where #S-102, #S-108, #S-100, #S-106 met with the Nurse Manager and the Director of Care about their concerns.

Inspector #577 met with #S-100 in January 2015. #S-100 reported witnessing incidents of verbal abuse by staff member #S-105 toward residents and neglecting to give residents tub baths from May-November 2014 and swearing at Residents #002, #006, #005 and #003. #S-100 reported hearing #S-105 swearing and speaking to Resident #003 in a derogatory way on a frequent basis. They also reported witnessing #S-105 consistently using unsafe resident transfers, such as transferring residents with a mechanical lift without assistance for the past 8 months. It was further reported that #S-105 refused to toilet residents and would use inappropriate briefs on residents. #S-100 reported that on a day in September 2014, Resident #003 was very ill and witnessed #S-105 refuse to assist resident and stated, "They can do it on their own, they can transfer them-self on their own". #S-105 was swearing in reference to the resident. They also reported an incident in November 2014, where #S-105 left Resident #003 in bed all day without a bath, no food or drink and another staff member found resident to be unwell. #S-100 reported that #S-105 stated Resident #003 yelled at them that morning so they left.

#S-100 reported speaking with the Nurse Manager about these concerns in June, August and October 2014. A group of staff met in November 2014, with the Nurse Manager and Director of Care. #S-100 reported that the Nurse Manager and Director of Care informed them that they would do their own investigation.

In January 2015, Inspector spoke with #S-102, who reported witnessing #S-105 frequently swear at Residents #005, #003, #006 and #002, from October-December 2014. Specifically towards Resident #003, on a constant basis in their room. It was further reported that when Resident #002 rang their call bell for assistance, #S-105 would respond angrily, "What do you want, why are you ringing?" #S-102 also reported that #S-105 used unsafe transfers for residents requiring the assistance of 2 staff for mechanical lifts. They also reported #S-105 was refusing to give tub baths to Residents #003, #005, #006 and #002 from October-December 2014 and used an incorrect brief on Resident #005 during a day and evening shift, only provided continence care to the resident once during their shift. Furthermore they stated that Resident #010 had a health episode when alone in their room in October 2014, when #S-105 was supposed to be with resident. #S-102 reported meeting as a group with the Nurse Manager and Director of Care in November 2014. They voiced concerns about #S-105 swearing at residents, neglecting to give resident tub baths, using improper briefs for their convenience and Resident #010's health episode.

During a review of #S-105's file in January 2015, Inspector #577 found a disciplinary letter to #S-105 from Human Resources concerning an incident from February 2012. Where #S-105 inappropriately transferred a resident.

In January 2015, Inspector #577 attempted to interview residents #002, #005, and #006 but they were unable to be interviewed.

Inspector #577 reviewed notes from an October 2014, meeting between #S-105, the Director of Care and the Nurse Manager. Notes indicated that #S-105 was told by the Director of Care that disrespect is a form of abuse, and to remember the Principles of Conduct.

In January 2015, Inspector #577 reviewed two separate meeting notes dated November 2014, regarding concerns brought forward by staff. Notes indicated that #S-102, #S-108, #S-100, #S-106 met with the Nurse Manager and Director of Care to discuss #S-105's conduct. Notes also indicated that the Nurse Manager, #S-105, and #S-109 met and reviewed concerns brought forward by co-workers.

Inspector #577 interviewed the Nurse Manager in January 2015 and they reported that there had never been concerns about verbal abuse, swearing or neglect. The Nurse Manager reported that staff have said they had concerns about #S-105 resident care, concerns about how they talk to residents and that they did not think they were doing resident baths. The Nurse Manager reported they had not documented any staff concerns in notes and reported they had spoken to #S-105 about resident baths and conduct. It was further reported that the Nurse Manager had witnessed #S-105 raise their voice at a resident once.

In January 2015, Inspector #577 met with the Director of Care to discuss the meeting that was held in November 2014 to discuss staff concerns regarding resident care provided by #S-105. The Director of Care reported that staff were concerned about #S-105's performance, including not doing tub baths for a particular resident, lying on residents' beds and texting on their phone. The Director of Care further reported that they felt these staff were bullying and ganging up on #S-105 and that staff stated they had been approaching the Nurse Manager with concerns but nothing was being done. The Director of Care reported that they recalled concerns brought forward about #S-105 not providing tub baths to Resident #002, verbal abuse towards residents and not assisting Resident #003 to their bed when they were ill and needed care.

Inspector #577 reviewed the home's policy on "Zero Tolerance of Abuse and Neglect of Residents" dated January 2014. Policy defines verbal abuse as the use of vexatious comments that are known, or that ought to be known, to be unwelcome, embarrassing, offensive, threatening or degrading to another person (including swearing, insults or condescending language) which causes the person to believe their health and safety are at risk. Neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The policy states as people in authority, Directors/Managers/VP Long Term Care, the responsibility includes acting upon any awareness of abuse or neglect, whether there is a complaint or not and in the event of a complaint, to act promptly and cooperate fully in any investigation.

Staff #S-100, #S-102, #S-106 and #S-108 reported witnessing frequent verbal abuse and neglect towards residents by #S-105, from April-December 2014. Specifically, swearing and yelling toward residents, refusing to give residents tub baths, using unsafe resident transfer techniques, and using improper briefs on residents for staff's convenience. Staff reported that they related their concerns to management in June, August, September and November 2014. [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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone and neglect of a resident by the licensee or staff, that the licensee knows of, or that is reported to the licensee, was immediately investigated.

In October 2014, information was received by the MOHLTC concerning verbal abuse and neglect toward residents by #S-105. Specifically, swearing and yelling at residents, refusing to give residents tub baths, using unsafe resident transfer techniques for residents requiring mechanical lifts, using improper briefs on residents for staff's convenience and falsifying charting regarding tub baths. According to the information received, management had been informed of these concerns and nothing was being done.

During an interview with Inspector #577, #S-100 and #S-106 both reported that they had spoken to the Nurse Manager in June, August and September 2014 about resident abuse and neglect. #S-106 reported telling the Nurse Manager that they were reporting this to the Ministry of Health and was told, "You don't have to go that far, let me deal with it". They also reported a group meeting in November 2014, when staff members #S-102, #S-108, #S-100, #S-106 met with the Nurse Manager and Director of Care about these concerns. #S-102 reported they voiced concerns about #S-105 swearing at residents, neglecting to give resident tub baths, using improper briefs for their convenience and resident #010's health episode. #S-100 reported that the Nurse Manager and Director of Care informed the group that they would do their own investigation.

In January 2015, Inspector #577 reviewed two separate meeting notes dated November 2014, regarding concerns brought forward by staff. Notes indicate that #S-102, #S-108, #S-100, #S-106 met with the Nurse Manager and Director of Care to discuss #S-105's conduct. Notes also indicated that the Nurse Manager, #S-105 and #S-109 met and reviewed concerns brought forward by co-workers.

Inspector #577 interviewed the Nurse Manager in January 2015. They reported that staff have not come forward about verbal abuse, swearing or neglect. They also reported staff have continued to have concerns about #S-105 resident care, including how they talk to residents and that they did not think they were doing resident baths. The Nurse Manager confirmed they haven't documented any staff concerns in notes and have spoken to #S-105 about resident baths and conduct. They also stated that they had witnessed #S-105 raise their voice at a resident once.

Inspector #577 interviewed the Director of Care in January 2015 to discuss meeting held in November 2014 about staff concerns regarding resident care by #S-105. They reported that staff were concerned about #S-105's performance, such as not doing tub baths on a particular resident, lying on residents' beds and texting on their phone. They also reported that staff stated they had been approaching the Nurse Manager with concerns but nothing was being done. The DOC also reported they recalled concerns brought forward about #S-105 not providing tub baths to Resident #002, verbal abuse towards residents and not assisting Resident #003 to their bed when they were ill and needed care.

Inspector #577 reviewed the home's policy on "Zero Tolerance of Abuse and Neglect of Residents" dated January 2014. The policy stated as people in authority, Directors/Managers/VP Long Term Care, the responsibility includes acting upon any awareness of abuse or neglect, whether there is a complaint or not and in the event of a complaint, to act promptly and cooperate fully in any investigation.

Staff reported their concerns of resident abuse and neglect to management in June, August, September and as a group, in November 2014, and management failed to investigate. The Nurse Manager reported they had not documented any staff concerns in notes.[s. 23. (1) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director: 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. c. 8, s. 24 (1), 195 (2).

In October 2014, information was received by the Ministry of Health and Long-Term Care concerning verbal abuse and neglect toward residents by #S-105. Specifically, swearing and yelling at residents, refusing to give residents tub baths, using unsafe resident transfer techniques for residents requiring mechanical lifts, using improper briefs on residents for staff's convenience and falsifying charting regarding tub baths. According to the information received, management has been informed of these concerns.

In January 2015, Inspector #577 spoke with #S-106, who reported that they have

witnessed verbal abuse and neglect toward residents by #S-105. Specifically from July-September 2014, #S-105 was witnessed belittling resident #003 on a daily basis. It was further reported, that in September 2014, Resident #003 was ill and required assistance to get back into their bed. #S-106 reported that #S-105 refused to help resident and also stated that #S-105 has refused to give residents tub baths from April-October 2014, has witnessed #S-105 neglect to feed residents in dining room, was observed to be texting on their cell phone, and overheard #S-105 call Residents #003, #002 and #006 profane names many times throughout the summer and using profane language. It was further reported that #S-105 has consistently refused to care for Resident #002, and would leave resident in bed and not provide care for them. #S-106 reported that they spoke to the Nurse Manager in June, August and September 2014 about resident abuse and neglect. They reported telling the Nurse Manager that they were reporting this to the Ministry of Health, and was told, "You don't have to go that far, let me deal with it". A meeting was held in November 2014, where #S-102, #S-108, #S-100, #S-106 met with the Nurse Manager and the Director of Care about their concerns. #S-102 reported they voiced concerns about #S-105 swearing at residents, neglecting to give residents tub baths, using improper briefs for their convenience and resident #010's health episode. #S-100 reported that the Nurse Manager and Director of Care informed the group that they would do their own investigation.

In January 2015, Inspector #577 reviewed two separate meeting notes dated November 2014, regarding concerns brought forward by staff. Notes indicate that #S-102, #S-108, #S-100, #S-106 met with the Nurse Manager and Director of Care to discuss #S-105's conduct. Notes also indicated that the Nurse Manager, the Director of Care, #S-105 and #S-109, met and reviewed concerns brought forward by co-workers.

Inspector #577 interviewed the Nurse Manager in January 2015. They reported that staff have not come forward about verbal abuse, swearing or neglect. They also reported staff have continued to have concerns about #S-105 resident care, including how they talk to residents and that they did not think they were doing resident baths. The Nurse Manager confirmed they haven't documented any staff concerns in notes and have spoken to #S-105 about resident baths and conduct. They also stated that they had witnessed #S-105 raise their voice at a resident once. It was also confirmed by the Nurse Manager, that the licensee had not reported alleged abuse to the Director.

Inspector #577 interviewed the Director of Care in January 2015 to discuss meeting held in November 2014 about staff concerns regarding resident care by #S-105. They reported that staff were concerned about #S-105's performance, such as not doing tub

baths an a particular resident, lying on residents' beds and texting on their phone. It was further reported that they felt these staff were bullying and ganging up on #S-105. They also reported that staff stated they had been approaching the Nurse Manager with concerns but nothing was being done. Also reported they recalled concerns brought forward about #S-105 not providing tub baths to Resident #002, verbal abuse towards residents and not assisting Resident #003 to their bed when they were ill and needed care.

Inspector #577 reviewed the home's policy on "Zero Tolerance of Abuse and Neglect of Residents" dated January 2014. The policy stated as people in authority, Directors/Managers/VP Long Term Care, the responsibility includes acting upon any awareness of abuse or neglect, whether there is a complaint or not and in the event of a complaint, to act promptly and cooperate fully in any investigation. In the policy "Reporting and Notifications about Incidents of Abuse or Neglect, dated January 2014, stated "the decision about whether to submit a report on an alleged incident of abuse or neglect depends upon whether the circumstances of the alleged abuse or neglect meet the definitions of Abuse in Long Term Care Homes Act Section 2 (1). The policy also stated that the Director/designate and/or VP Long Term Care must be notified immediately and they will notify the Ministry by phone. Notification is followed by immediate initiation of the report using the on line Mandatory Critical Incident System form. The MCIS report is finalized and submitted within 10 days following awareness of the incident or at an earlier date if required by the Director, MOHLTC (LTCHA Section 24 (1)). The report includes, but is not limited to, the results of the investigation and any action in response to incident of abuse. [s. 24. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

In November 2014, the Ministry of Health and Long Term Care received information concerning a deceased Resident #001 being left in a shared resident room with Resident #011, for over 14 hours. It was reported that as the day progressed, a foul odor began lingering in the room and that the odor was so strong that other residents within close proximity of the room pointed it out. It was further reported that the decedent's room-mate, Resident #011, refused to enter the room and was left up in their wheelchair all day which caused them great distress and pain.

Upon record review, Inspector #577 found that Resident #001 passed away in November 2014, early in the morning. Registered Nurse contacted physician on call and obtained order to pronounce death.

In January 2015, Inspector #577 interviewed the Nurse Manager. They reported that a deceased body would stay in their room, until funeral home staff arrive. They further indicated that the certificate of death must be signed by physician first, before funeral home staff can pick up the resident's body and transport to the funeral home. They had to wait for physician to sign the death certificate before body could be removed. They confirmed that the decedent was sharing a room with Resident #011. They further reported that they closed the curtains around the decedent's body for privacy. [s. 3. (1) 1.]

Issued on this 14th day of August, 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577)
Inspection No. / No de l'inspection :	2015_333577_0004
Log No. / Registre no:	S-008713-14 & S-006783-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 6, 2015
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	BETHAMMI NURSING HOME 63 CARRIE STREET, THUNDER BAY, ON, P7A-4J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Meaghan Sharp

To ST. JOSEPH'S CARE GROUP, 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 ensure that residents #002, #003, #005, #006, #007, #008, #009, #010, and any other resident, of the long-term care home are protected from abuse by anyone and that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Under O.Reg. 79/10, verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's well-being, dignity or self-worth, that is made by anyone other than a resident". Neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

In October 2014, information was received by the Ministry of Health and Long-Term Care concerning verbal abuse and neglect toward residents by #S-105. Specifically, swearing and yelling at residents, refusing to give residents tub baths, using unsafe resident transfer techniques for residents requiring mechanical lifts, and falsifying charting regarding tub baths. According to the information received, management has been informed of these concerns.

In October 2014, further information was received by the Ministry of Health and

Long-Term Care concerning abuse and neglect toward residents by #S-105. Specifically verbal abuse towards residents and refusing to give baths to residents. According to the information received these concerns have been discussed with management and feels nothing is being done. They also indicated that staff are worried about the residents.

In January 2015, Inspector #577 spoke with #S-106, who reported that they have witnessed verbal abuse and neglect toward residents by #S-105. Specifically from July-September 2014, #S-105 was witnessed belittling resident #003 on a daily basis. It was further reported, that on a day in September 2014, Resident #003 was ill and required assistance to get back in to their bed. #S-106 reported that #S-105 refused to help resident and also stated that #S-105 has refused to give residents tub baths from April-October 2014, has witnessed #S-105 neglect to feed residents in dining room and overheard #S-105 call Residents #003, #002 and #006 profane names many times throughout the summer and used profane language. It was further reported that #S-105 has consistently refused to care for Resident #002 and would leave the resident in bed. #S-106 reported that they spoke to the Nurse Manager in June, August and September 2014 about resident abuse and neglect. They reported telling the Nurse Manager that they were reporting this to the Ministry of Health, and was told, "You don't have to go that far, let me deal with it". A meeting was held in November 2014, where #S-102, #S-108, #S-100, #S-106 met with the Nurse Manager and the Director of Care about their concerns.

Inspector #577 met with #S-100 in January 2015. #S-100 reported witnessing incidents of verbal abuse by staff member #S-105 toward residents and neglecting to give residents tub baths from May-November 2014 and swearing at Residents #002, #006, #005 and #003. #S-100 reported hearing #S-105 swearing and speaking to Resident #003 in a derogatory way on a frequent basis. They also reported witnessing #S-105 consistently using unsafe resident transfers, such as transferring residents with a mechanical lift without assistance for the past 8 months. It was further reported that #S-105 refused to toilet residents and would use inappropriate briefs on residents. #S-100 reported that on a day in September 2014, Resident #003 was very ill and witnessed #S-105 refuse to assist resident and stated, "They can do it on their own, they can transfer them-self on their own". #S-105 was swearing in reference to the resident. They also reported an incident in November 2014, where #S-105 left Resident #003 in bed all day without a bath, no food or drink and another staff member found resident to be unwell. #S-100 reported that #S-105 stated

Resident #003 yelled at them that morning so they left.

#S-100 reported speaking with the Nurse Manager about these concerns in June, August and October 2014. A group of staff met in November 2014, with the Nurse Manager and Director of Care. #S-100 reported that the Nurse Manager and Director of Care informed them that they would do their own investigation.

In January 2015, Inspector spoke with #S-102, who reported witnessing #S-105 frequently swear at Residents #005, #003, #006 and #002, from October-December 2014. Specifically towards Resident #003, on a constant basis in their room. It was further reported that when Resident #002 rang their call bell for assistance, #S-105 would respond angrily, "What do you want, why are you ringing?" #S-102 also reported that #S-105 used unsafe transfers for residents requiring the assistance of 2 staff for mechanical lifts. They also reported #S-105 was refusing to give tub baths to Residents #003, #005, #006 and #002 from October-December 2014 and used an incorrect brief on Resident #005 during a day and evening shift, only provided continence care to the resident once during their shift. Furthermore they stated that Resident #010 had a health episode when alone in their room in October 2014, when #S-105 was supposed to be with resident. #S-102 reported meeting as a group with the Nurse Manager and Director of Care in November 2014. They voiced concerns about #S-105 swearing at residents, neglecting to give resident tub baths, using improper briefs for their convenience and Resident #010's health episode.

During a review of #S-105's file in January 2015, Inspector #577 found a disciplinary letter to #S-105 from Human Resources concerning an incident from February 2012. Where #S-105 inappropriately transferred a resident.

In January 2015, Inspector #577 attempted to interview residents #002, #005, and #006 but they were unable to be interviewed.

Inspector #577 reviewed notes from an October 2014, meeting between #S-105, the Director of Care and the Nurse Manager. Notes indicated that #S-105 was told by the Director of Care that disrespect is a form of abuse, and to remember the Principles of Conduct.

In January 2015, Inspector #577 reviewed two separate meeting notes dated November 2014, regarding concerns brought forward by staff. Notes indicated

that #S-102, #S-108, #S-100, #S-106 met with the Nurse Manager and Director of Care to discuss #S-105's conduct. Notes also indicated that the Nurse Manager, #S-105, and #S-109 met and reviewed concerns brought forward by co-workers.

Inspector #577 interviewed the Nurse Manager in January 2015 and they reported that there had never been concerns about verbal abuse, swearing or neglect. The Nurse Manager reported that staff have said they had concerns about #S-105 resident care, concerns about how they talk to residents and that they did not think they were doing resident baths. The Nurse Manager reported they had not documented any staff concerns in notes and reported they had spoken to #S-105 about resident baths and conduct. It was further reported that the Nurse Manager had witnessed #S-105 raise their voice at a resident once.

In January 2015, Inspector #577 met with the Director of Care to discuss the meeting that was held in November 2014 to discuss staff concerns regarding resident care provided by #S-105. The Director of Care reported that staff were concerned about #S-105's performance, including not doing tub baths for a particular resident, lying on residents' beds and texting on their phone. The Director of Care further reported that they felt these staff were bullying and ganging up on #S-105 and that staff stated they had been approaching the Nurse Manager with concerns but nothing was being done. The Director of Care reported that they recalled concerns brought forward about #S-105 not providing tub baths to Resident #002, verbal abuse towards residents and not assisting Resident #003 to their bed when they were ill and needed care.

Inspector #577 reviewed the home's policy on "Zero Tolerance of Abuse and Neglect of Residents" dated January 2014. Policy defines verbal abuse as the use of vexatious comments that are known, or that ought to be known, to be unwelcome, embarrassing, offensive, threatening or degrading to another person (including swearing, insults or condescending language) which causes the person to believe their health and safety are at risk. Neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The policy states as people in authority, Directors/Managers/VP Long Term Care, the responsibility includes acting upon any awareness of abuse or neglect,

whether there is a complaint or not and in the event of a complaint, to act promptly and cooperate fully in any investigation.

Staff #S-100, #S-102, #S-106 and #S-108 reported witnessing frequent verbal abuse and neglect towards residents by #S-105, from April-December 2014. Specifically, swearing and yelling toward residents, refusing to give residents tub baths, using unsafe resident transfer techniques, and using improper briefs on residents for staff's convenience. Staff reported that they related their concerns to management in June, August, September and November 2014. [s. 19. (1)] (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 10, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall ensure that, for residents #002, #003, #005, #006, #007, #008, #009, #010 and any other resident, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, and that appropriate action is taken in response to every such incident including any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) 2007, c. 8, s. 23 (1).

Grounds / Motifs :

1. The licensee has failed to ensure that , (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, was immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

In October 2014, information was received by the MOHLTC concerning verbal abuse and neglect toward residents by #S-105. Specifically, swearing and yelling at residents, refusing to give residents tub baths, using unsafe resident transfer techniques for residents requiring mechanical lifts, using improper briefs on residents for staff's convenience and falsifying charting regarding tub baths. According to the information received, management had been informed of these concerns and nothing was being done.

During an interview with Inspector #577, #S-100 and #S-106 both reported that they had spoken to the Nurse Manager in June, August and September 2014 about resident abuse and neglect. #S-106 reported telling the Nurse Manager that they were reporting this to the Ministry of Health and was told, "You don't have to go that far, let me deal with it". They also reported a group meeting in November 2014, when staff members #S-102, #S-108, #S-100, #S-106 met with the Nurse Manager and Director of Care about these concerns. #S-102 reported they voiced concerns about #S-105 swearing at residents, neglecting to give resident tub baths, using improper briefs for their convenience and resident #010's health episode. #S-100 reported that the Nurse Manager and Director of Care informed the group that they would do their own investigation.

In January 2015, Inspector #577 reviewed two separate meeting notes dated November 2014, regarding concerns brought forward by staff. Notes indicate that #S-102, #S-108, #S-100, #S-106 met with the Nurse Manager and Director of Care to discuss #S-105's conduct. Notes also indicated that the Nurse Manager, #S-105 and #S-109 met and reviewed concerns brought forward by co-workers.

Inspector #577 interviewed the Nurse Manager in January 2015. They reported that staff have not come forward about verbal abuse, swearing or neglect. They also reported staff have continued to have concerns about #S-105 resident care, including how they talk to residents and that they did not think they were doing resident baths. The Nurse Manager confirmed they haven't documented any staff concerns in notes and have spoken to #S-105 about resident baths and conduct. They also stated that they had witnessed #S-105 raise their voice at a resident once.

Inspector #577 interviewed the Director of Care in January 2015 to discuss meeting held in November 2014 about staff concerns regarding resident care by

#S-105. They reported that staff were concerned about #S-105's performance, such as not doing tub baths on a particular resident, lying on residents' beds and texting on their phone. They also reported that staff stated they had been approaching the Nurse Manager with concerns but nothing was being done. The DOC also reported they recalled concerns brought forward about #S-105 not providing tub baths to Resident #002, verbal abuse towards residents and not assisting Resident #003 to their bed when they were ill and needed care.

Inspector #577 reviewed the home's policy on "Zero Tolerance of Abuse and Neglect of Residents" dated January 2014. The policy stated as people in authority, Directors/Managers/VP Long Term Care, the responsibility includes acting upon any awareness of abuse or neglect, whether there is a complaint or not and in the event of a complaint, to act promptly and cooperate fully in any investigation.

Staff reported their concerns of resident abuse and neglect to management in June, August, September and as a group, in November 2014, and management failed to investigate. The Nurse Manager reported they had not documented any staff concerns in notes.[s. 23. (1) (a)]
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 10, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports 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. c. 8, s. 24 (1), 195 (2).

Grounds / Motifs :

1. The licensee has failed to ensure that s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director: 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. c. 8, s. 24 (1), 195 (2).

In October 2014, information was received by the Ministry of Health and Long-Term Care concerning verbal abuse and neglect toward residents by #S-105. Specifically, swearing and yelling at residents, refusing to give residents tub baths, using unsafe resident transfer techniques for residents requiring

mechanical lifts, using improper briefs on residents for staff's convenience and falsifying charting regarding tub baths. According to the information received, management has been informed of these concerns.

In January 2015, Inspector #577 spoke with #S-106, who reported that they have witnessed verbal abuse and neglect toward residents by #S-105. Specifically from July-September 2014, #S-105 was witnessed belittling resident #003 on a daily basis. It was further reported, that in September 2014, Resident #003 was ill and required assistance to get back into their bed. #S-106 reported that #S-105 refused to help resident and also stated that #S-105 has refused to give residents tub baths from April-October 2014, has witnessed #S-105 neglect to feed residents in dining room, was observed to be texting on their cell phone, and overheard #S-105 call Residents #003, #002 and #006 profane names many times throughout the summer and using profane language. It was further reported that #S-105 has consistently refused to care for Resident #002, and would leave resident in bed and not provide care for them. #S-106 reported that they spoke to the Nurse Manager in June, August and September 2014 about resident abuse and neglect. They reported telling the Nurse Manager that they were reporting this to the Ministry of Health, and was told, "You don't have to go that far, let me deal with it". A meeting was held in November 2014, where #S-102, #S-108, #S-100, #S-106 met with the Nurse Manager and the Director of Care about their concerns. #S-102 reported they voiced concerns about #S-105 swearing at residents, neglecting to give residents tub baths, using improper briefs for their convenience and resident #010's health episode. #S-100 reported that the Nurse Manager and Director of Care informed the group that they would do their own investigation.

In January 2015, Inspector #577 reviewed two separate meeting notes dated November 2014, regarding concerns brought forward by staff. Notes indicate that #S-102, #S-108, #S-100, #S-106 met with the Nurse Manager and Director of Care to discuss #S-105's conduct. Notes also indicated that the Nurse Manager, the Director of Care, #S-105 and #S-109, met and reviewed concerns brought forward by co-workers.

Inspector #577 interviewed the Nurse Manager in January 2015. They reported that staff have not come forward about verbal abuse, swearing or neglect. They also reported staff have continued to have concerns about #S-105 resident care, including how they talk to residents and that they did not think they were doing resident baths. The Nurse Manager confirmed they haven't documented any

staff concerns in notes and have spoken to #S-105 about resident baths and conduct. They also stated that they had witnessed #S-105 raise their voice at a resident once. It was also confirmed by the Nurse Manager, that the licensee had not reported alleged abuse to the Director.

Inspector #577 interviewed the Director of Care in January 2015 to discuss meeting held in November 2014 about staff concerns regarding resident care by #S-105. They reported that staff were concerned about #S-105's performance, such as not doing tub baths an a particular resident, lying on residents' beds and texting on their phone. It was further reported that they felt these staff were bullying and ganging up on #S-105. They also reported that staff stated they had been approaching the Nurse Manager with concerns but nothing was being done. Also reported they recalled concerns brought forward about #S-105 not providing tub baths to Resident #002, verbal abuse towards residents and not assisting Resident #003 to their bed when they were ill and needed care.

Inspector #577 reviewed the home's policy on "Zero Tolerance of Abuse and Neglect of Residents" dated January 2014. The policy stated as people in authority, Directors/Managers/VP Long Term Care, the responsibility includes acting upon any awareness of abuse or neglect, whether there is a complaint or not and in the event of a complaint, to act promptly and cooperate fully in any investigation. In the policy "Reporting and Notifications about Incidents of Abuse or Neglect, dated January 2014, stated "the decision about whether to submit a report on an alleged incident of abuse or neglect depends upon whether the circumstances of the alleged abuse or neglect meet the definitions of Abuse in Long Term Care Homes Act Section 2 (1). The policy also stated that the Director/designate and/or VP Long Term Care must be notified immediately and they will notify the Ministry by phone. Notification is followed by immediate initiation of the report using the on line Mandatory Critical Incident System form. The MCIS report is finalized and submitted within 10 days following awareness of the incident or at an earlier date if required by the Director, MOHLTC (LTCHA Section 24 (1)). The report includes, but is not limited to, the results of the investigation and any action in response to incident of abuse. [s. 24. (1)]
(577)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 10, 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 6th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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