Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2020	2020_633577_0021	011004-20, 013209-20, 015938-20, 016059-20, 017841-20, 018860-20	Critical Incident System

Licensee/Titulaire de permis

Nipigon District Memorial Hospital
125 Hogan Road NIPIGON ON P0T 2J0

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

Nipigon District Memorial Hospital
125 Hogan Road P.O. Box 37 NIPIGON ON P0T 2J0

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

DEBBIE WARPULA (577), MELISSA HAMILTON (693)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 13 to 16, and 19 to 23, 2020

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
-Three logs submitted to the Director for allegations of staff to resident neglect and verbal abuse;
-One log submitted to the Director for allegations of staff to resident physical abuse;
-One log submitted to the Director for allegations of staff neglect and medication; and
-One log submitted to the Director for a fall with a fracture.

Follow up inspection #2020_633577_0022 was conducted concurrently with this Critical Incident System (CIS) inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurses (RPNs), LTC Lead, Personal Support Workers (PSWs), Registered Nurse Quality Assurance and Infection Control, Maintenance worker, Infection Control Manager, Activity Coordinator, Physiotherapist and Information Technologist (IT).

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

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **1 VPC(s)**
- **8 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment

for its residents.

The Chief Medical Officer of Health (CMOH) issued Directive #3 on September 9, 2020, which required long-term care homes to immediately implement active screening of all staff, visitors and anyone else entering the home for COVID-19. Anyone showing symptoms of COVID-19 must not be allowed to enter the home and that all staff wear surgical/procedure masks at all times.

On a day in October 2020, Inspector #577 observed a staff member on the long term care unit walking around the nursing station without a surgical/procedure mask.

On another day in October 2020, Inspector #577 observed another staff member without a surgical/procedure mask, walking through the resident's hallway adjacent to the resident rooms.

On that same day, Inspector #577 observed another staff member standing at the nursing station, and walking around the nursing station without a surgical/procedure mask.

During an interview with the RN/Quality Assurance and Infection Control, they advised that they had been instructed by the Infection Control Manager that they didn't need to don a mask as long as they maintained a two meter distance and spent a limited amount of time on the unit.

A review of the home's policies "Universal Mask Use in Health Care Settings and Long Term Care (COVID-19) – 5-45", effective August 5, 2020, and "Management Guidelines for Covid-19 in Long Term Care – LTC-2-02", effective September 30, 2020, indicated that all staff were required to wear a surgical/procedure mask at all times. During breaks staff could remove their mask but must remain two meters away from other staff to prevent staff to staff transmission of COVID-19. Universal masking of staff and essential visitors was intended to reduce the risk of transmitting COVID-19 from staff or essential visitors to residents or other staff. Essential visitors included a person performing essential support services (food delivery, phlebotomy testing, maintenance, and other health care services required to maintain good health).

Sources: the home's policies Universal Mask Use in Health Care Settings and Long Term Care COVID-19, and Management Guidelines for Covid-19 in Long Term Care, observations of staff and interviews with the DOC and other staff. [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised at least every six months, and at any other time when the resident's care needs change or care set out in the plan was no longer necessary, with respect to falls interventions.

A Critical Incident System (CIS) report was submitted to the Director for an incident that caused injury to a resident, for which the resident was taken to the hospital and resulted in a significant change in the resident's health status.

Inspector #693 reviewed the resident's electronic health records and identified that the resident was assessed as being a high fall risk on a specific assessment. The Inspector reviewed the resident's plans of care that were in effect over a specified time period, and identified that there was no focus specific to falls, as well as no falls prevention interventions for the resident.

During an interview with the DOC, they indicated that when the resident was assessed as a high falls risk, their care plan should have been updated to include a focus specific to falls, as well as falls prevention interventions. Additionally, the DOC indicated that after the resident fell, their care plan should have been updated to reflect the resident's care

needs.

Sources:Critical Incident System report, the home's investigation file, resident's medical record; resident's care plans, the home's policy Admission to Long Term Care, the home's policy Falls Prevention and Management, interviews with the DOC and other staff. [s. 6. (10) (b)]

2. The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised at least every six months, and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary, with respect to restraints.

During an interview with the LTC Lead they identified that a resident had two unwitnessed falls on two days in October 2020.

Inspector #693 reviewed the resident's current care plan, which indicated that the resident utilized a particular intervention, at all times, when in bed.

During an Interview with the DOC, they indicated that this intervention was removed months ago when the resident transitioned to a long-term care resident. The DOC indicated that the care plan should have been revised and updated when the intervention was removed, to meet the resident's current care needs.

Sources: resident's medical record, resident's care plan, the home's policy Admission to Long Term Care, interviews with the DOC and other staff. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with, in respect to physical abuse of a resident.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

During an interview with an RPN, they advised Inspector #577 that a resident reported to them that an RPN was inappropriate with their transfers, verbally abusive and belittling, it had been going on for a long time, and they were afraid when they arrived on their shift. They further advised that they reported this to the DOC four days later.

A review of home's policy, "Zero Tolerance of Abuse and Neglect of Residents - LTC-20-01", effective October 2019, indicated that all residents had the right to live in a home environment that treated them with dignity, respect and was free from any form of abuse or neglect at all times, and in all circumstances. They were committed to ensuring that the residents were protected from abuse and would ensure they were not neglected by the licensee or staff. It was the expectation that their employees protected their residents from abuse and neglect by anyone. A staff member was guilty of an offense if they failed to fulfill their legal obligation to make a report for alleged, suspected or witnessed abuse and neglect of a resident to the Administrator.

A review of the investigation file indicated that the resident stated they felt abused by the RPN; the RPN failed to have followed the home’s Zero Tolerance of Abuse and Neglect policy; another RPN notified the DOC four days later after the resident told them that the RPN physically abused them, was inappropriate with their transfers and the resident felt too afraid to come forward; an email from the Administrator that indicated a conversation where the RPN confirmed that they were inappropriate when assisting the resident with a

particular care activity and they had not denied the allegation.

During an interview with the resident, they reported to Inspector #577 that there were three incidents when the RPN handled them inappropriately during a particular care activity; reported that on the third incident, the RPN picked them up from their bed and ‘plunked’ them onto a specific apparatus and they experienced pain to an area of their body. Reported that they told the RPN that they wanted to walk to the bathroom and the RPN insisted that they used a specific apparatus. They further reported that they felt scared everytime they were on shift because of the way they treated them and felt it was abuse. They further advised that they had told another RPN about the RPN being inappropriate with a particular care activity.

During an interview with the DOC, they advised that they determined physical abuse of the resident by the RPN, and staff didn't follow the abuse policy as the other RPN failed to immediately report the allegation made by the resident, until four days later.

Sources: Critical Incident System report, progress notes, investigation notes, the home’s Zero Tolerance of Abuse and Neglect of Residents, and interviews with an RPN and other staff. [s. 20. (1)]

2. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with, in respect to verbal abuse of a resident.

According to the Long-Term Care Homes Act, 2007 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”.

A review of the home’s policy, “Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect - LTC-20-03", effective October 2019, indicated that their employees had an obligation to protect their residents from abuse by anyone, ensure that they were not neglected by the licensee or staff and report any alleged, suspected or witnessed abuse or neglect. All staff were required to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect, at the time of a witnessed or alleged incident, to the Administrator of the home. The Administrator must investigate immediately all reports of abuse or neglect.

A review of the CIS report indicated that a resident reported that a PSW often yelled at them to get up at particular times when they were not ready or did not want to get up. They also reported that they've heard them yell at another resident and ignore particular needs of another resident. The resident voiced concerns of retaliation from the PSW if they were made aware of them being reported by the resident.

A review of the investigation notes revealed an interview with the Activity Coordinator and the DOC. The notes indicated that the Activity Coordinator reported that the PSW was often spoke to residents in a particular way.

During an interview with the resident, they advised Inspector #577 that the PSW yelled at them to get out of bed at particular times and yelled at two other residents.

During an interview with the DOC, they advised Inspector #577 that they determined verbal abuse by the PSW towards three residents.

Sources: Critical Incident System report, progress notes, investigation notes, the home's policy Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect, and interviews with the DOC and other staff. [s. 20. (1)]

3. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with, in respect to verbal abuse of a resident.

A CIS report was submitted to the Director regarding an allegation of verbal abuse by an RPN. The report indicated that a resident reported to the Administrator that they overheard an RPN yelling a particular statement at another resident in the hallway, as well that the RPN had made a particular statement towards them. The report indicated that the resident had expressed concerns of suffering repercussions if the RPN knew they were raising these concerns.

During an interview with the DOC they indicated that the RPN's actions toward the resident and the other resident constituted verbal abuse as per the legislation, and that their actions did not comply with the home's abuse policy.

Sources: Critical Incident System report, investigation file, interviews with the DOC and other staff, interview with the resident, an employee file, the home's policy Reporting,

Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect, the home's policy Zero Tolerance of Abuse and Neglect of Residents, the home's policy Professional Standards of Behaviour and the home's policy Code of Conduct. [s. 20. (1)]

4. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with, in respect to verbal abuse of a resident.

O. Reg. 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A CIS report was submitted to the Director for an allegation of emotional abuse. The CIS report indicated that the LTC Lead reported to the DOC that a resident’s family member had reported to them, that an RPN made particular statements towards a resident in a stern, abrupt and derogatory voice. The resident’s family member reported that the resident had indicated that they were made to feel as though they were in a prison.

The home’s investigation notes included documentation of an interview that the DOC had with the resident that indicated that the resident had indicated that the RPN was very upset and made a particular statement towards them.

During an interview with the DOC they indicated that the RPN's actions toward the resident constituted emotional abuse as per the legislation and that their actions did not comply with the home’s abuse policy.

Sources: Critical Incident System report, investigation file, interviews with the DOC and other staff, interview with the resident, resident’s care plan, progress notes, the home's policy Zero Tolerance of Abuse and Neglect of Residents. [s. 20. (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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

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

A review of the home's policy, "Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect - LTC-20-03", effective October 2019, indicated that all staff were required to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect, at the time of a witnessed or alleged incident, to the Administrator of the home.

During an interview with an RPN they advised Inspector #577 that a resident reported to them that an RPN was inappropriate with a particular care activity, verbally abusive and belittling, it had been going on for a long time, and they were afraid when they arrived on their shift. They further advised that they reported this to the DOC four days later; they acknowledged that it should have been reported immediately and that they were afraid of the repercussions of reporting this against the RPN and what could potentially happen to them; they stated that it was not easy reporting a co-worker and they were afraid of repercussions and/or retaliation against themselves for reporting.

During an interview with the resident, they reported to Inspector #577 that they had told an RPN about another RPN being inappropriate with a particular care activity.

During an interview with the Activity Coordinator, they advised Inspector #577 that the resident had told them that they wanted to make a complaint about an RPN handling them a particular way. They reported to the Inspector that they didn't report it and the resident later told them that they reported it to an RPN.

A review of the investigation notes indicated that the resident told an RPN that the physical abuse by another RPN had been going on for awhile and the resident felt too afraid to report it.

During an interview with the DOC, they advised that the RPN had not followed the abuse policy as they didn't immediately report the allegation made by the resident, until four days later.

b) During an interview with an RPN, they advised Inspector #577 that the resident had told them that an RPN had been withholding a particular medication. They further advised that another RPN overheard the conversation between the resident and themselves, and an RPN reported this information to the RPN. The RPN stated that they had not reported this allegation made by the resident. They advised that another RPN disclosed the allegation to the RPN.

A review of the investigation file revealed that an RPN reported to the DOC that another RPN had told them that they overheard the resident tell them that they had been withholding medication from the resident.

During an interview with the DOC, they advised that both RPNs should have reported the resident's allegation immediately.

Sources: two Critical Incident System reports, progress notes, investigation notes, the home's policy Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect, employee files, interview with the resident, interviews with an RPN and other staff. [s. 24. (1) 2.]

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by the licensee or staff that resulted in harm or a risk of

harm to the resident had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director regarding an allegation of verbal abuse by an RPN towards a resident.

During an interview with the DOC, they indicated that this allegation of verbal abuse was not immediately reported to the Director and should have been.

Sources: Critical Incident System report, investigation file, interviews with the DOC and other staff, interview with a resident, the home's policy Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect. [s. 24. (1) 2.]

3. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director for an allegation of emotional abuse.

A review of the home’s investigation file identified a document composed by the LTC Lead which indicated that a resident’s family member reported the allegation of emotional abuse to the LTC Lead.

During an interview with the DOC they indicated they when they had learned of the allegation of emotional abuse of the resident, they should have reported it to the Director then, as well that the LTC Lead should have reported the incident to management when they had received the allegation.

Sources: Critical Incident System report, investigation file, interviews with the DOC and other staff, interview with a resident, the home's policy Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect, the home's policy Zero Tolerance of Abuse and Neglect of Residents. [s. 24. (1) 2.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was complied with in respect to each of the organized programs required under section 8 to 16 of the Act, and each of the interdisciplinary programs required under section 48 of Ontario Regulation 79/10.

Specifically, the licensee has failed to ensure that the Falls Prevention and Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A Critical Incident System (CIS) report was submitted to the Director for an incident that caused injury to a resident.

Inspector #693 reviewed the home's policy, "Falls Prevention and Management, NUR 101", revised July 2017. There was no indication in the policy, for a post falls assessment instrument to be completed, or for an HIR to be implemented longer than 28 hours post fall; as well no indication of monitoring vital signs, or monitoring for changes in behaviour for any witnessed falls without suspected head injury, and no indication to complete pain assessments after a fall, of any kind.

During an interview with the DOC, they indicated that the home's Falls program needed to be updated and revised to include current evidence-based practices, including a post falls assessment.

Sources: the home's policy Falls Prevention and Management, interviews with the DOC and other staff. [s. 30. (1) 1.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning

devices or techniques when assisting a resident from their bed to their commode.

The home's policy, "Patient Transfers using Transfer Tree – NUR- 54", effective March 2014, indicated that staff were to assess a resident's knee strength prior to assisting with a transfer, by having them extend one or both knees which determined if they could sustain gravity to stand. If the resident was unable, a mechanical lift was to be used.

The care plan for the resident indicated that they required a specified level of assistance with a particular care activity.

During an interview with an RPN they advised that the resident was assessed as requiring specific assistance with an activity. They stated that they recalled an incident where they had provided assistance and handled the resident in a particular way. They advised that after the activity, the resident complained of pain and that they should have requested a second staff member to assist them.

During an interview with the PT, they reported that staff should never provide assistance in a particular way, and it was considered an unsafe.

Sources: Critical Incident System report, progress notes, investigation notes, the home's policy Patient Transfers using Transfer Tree, and interviews with the PT and other staff. [s. 36.]

2. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident off the floor after a fall.

Inspector #693 reviewed the resident's medical record, related to a fall they sustained. The medical record included a specific report that indicated the resident was assisted in a particular way.

During an interview with the DOC, they indicated that the resident's care plan identified they were to always be assisted using a specific device after an incident. They advised that it was an improper intervention as the home's falls policy and patient transfers policy indicated that in this situation, a specific device should have been utilized with the assistance of two staff members, to complete the care activity of the resident.

Sources: resident's health record, progress notes, plan of care, the home's policy Falls Prevention and Management, the home's policy Patient Transfers Using Transfer Tree,

interviews with the DOC and other staff. [s. 36.]

3. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

During an interview the LTC Lead identified that the resident sustained two unwitnessed falls on two days in October 2020.

Inspector #693 reviewed the resident's medical record, related to the falls they sustained. The medical record included a specific report for one of the resident's falls, that indicated the resident was assisted by a particular number of staff members, into their mobility aid.

During an interview with the DOC, they advised that this was an improper intervention as the home's falls policy and patient transfers policy indicated that in this situation a specific device should have been utilized with the assistance of two staff members, to complete care activity.

Sources: resident's health record, progress notes, plan of care, the home's policy Falls Prevention and Management, the home's policy Patient Transfers Using Transfer Tree, interviews with the DOC and other staff. [s. 36.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home, with respect to a resident's fall.

A Critical Incident System (CIS) report was submitted to the Director for a fall that caused injury to a resident, for which the resident was taken to the hospital and resulted in a significant change in the resident's health status. The report further identified that it was an unwitnessed fall, and the resident had sustained an injury.

Inspector #693 reviewed the progress notes for the resident and identified that the resident sustained two unwitnessed falls.

During an interview with the DOC, they indicated that a specific report was only completed for one of the falls, and should have been completed for both falls, as well, a specific routine should have been completed for both falls, which included specific monitoring for a particular number of hours, but was only started for one fall and not completed in full, and for the other fall not implemented. In addition, the DOC indicated that a specific risk assessment should have been completed after each fall and was not. The DOC indicated that another specific assessment was not completed for either fall.

Sources: Critical Incident System report, investigation file, resident's medical record, resident's plan of care, the home's Falls Prevention and Management, interviews with the

DOC and other staff. [s. 48. (1) 1.]

2. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home, with respect to a resident's fall.

During an interview the LTC Lead identified that the resident sustained a fall and suffered an injury.

During an interview with the DOC, they indicated that the resident’s fall was witnessed by staff.

The DOC stated that the home’s falls management program was not implemented for the resident’s fall as a specific routine was not completed in full for a number of required hours and their care plan wasn't updated. The DOC indicated that a specific assessment was not completed after the fall.

Sources: resident’s health record, progress notes, plan of care, the home's policy Falls Prevention and Management, interviews with the DOC and other staff. [s. 48. (1) 1.]

3. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home, with respect to a resident's fall.

During an interview, the LTC Lead identified that the resident sustained two unwitnessed falls on two separate days.

During an interview with the DOC, they indicated that both of the resident’s falls were unwitnessed. The DOC advised that the home’s falls management program was not implemented for the resident’s fall as a specific routine was not completed for either fall, a specific risk assessment was not saved in MED e-care after each fall, and the resident’s care plan was not updated, as the program had required. The DOC indicated that a specific assessment was not completed after either fall.

Sources: resident’s health record, progress notes, plan of care, the home's policy Falls Prevention and Management, interviews with the DOC and other staff. [s. 48. (1) 1.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written medication management policies and protocols were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, with respect to two residents.

Specifically, staff did not comply with the licensee's policies regarding "Medication Administration -5.1" and "High Alert/Risk Medications and/or Medication Administration Situations – NUR – 132".

The College of Nurses of Ontario Practice Standard, titled, 'Medication-2019', indicated that nurses promoted safe care, and contributed to a culture of safety within their practice environments, when involved in medication practices.

a) During an observation of a medication pass, Inspector #577 observed an RPN prepare and administer a particular medication to a resident, without a second registered staff performing an independent double check. During an interview with the RPN, they advised that they should have called a registered staff member from the acute care side to double check the medication.

A review of the home's policy, "High Alert/Risk Medications and/or Medication Administration Situations – NUR – 132", effective April 2017, indicated that the particular medication was considered a high alert medication and all high alert medications required an independent double check.

During an interview with the DOC, they advised that the RPN had not followed the medication policy.

b) A review of the home's investigation file indicated that a resident had reported to an RPN that another RPN had been withholding a particular scheduled medication. The results of the investigation determined that the RPN had been administering a resident's three scheduled medications at a particular time; they were not following the home's policy in regards to Standard Administration Times, and the incident was a medication incident.

A review of the home's policy, "Medication Administration -5.1", effective March 2020, indicated that the home would establish a standard schedule of medication administration times based on the resident needs and characteristics of the medication regimen; medications were to be given within one hour of the scheduled administration time.

During an interview with the RPN, they advised that they had administered a resident's three scheduled medications at a particular time, and one of the medications was administered outside the one hour window.

During an interview with DOC, they advised that their investigation determined that the RPN was administering one of the resident's scheduled medication outside the one hour window and it was a medication incident.

Sources: Critical Incident System report, progress notes, investigation notes, the home's policy High Alert/Risk Medications and/or Medication Administration Situations, the home's policy Medication Administration, and interviews with an RPN and other staff. [s. 114. (3) (a)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to include the outcome in making a report to the Director under subsection 23(2) of the Act, with respect to the alleged, suspected or witnessed incident of abuse of a resident.

A CIS report was submitted to the Director regarding an allegation of verbal abuse by an RPN. The CIS report indicated that a resident reported to the Administrator that they overheard an RPN yelling a particular statement at another resident in the hallway, as well that the RPN had made a particular statement towards them. The report indicated that the resident had expressed concerns of suffering repercussions if the RPN knew they raised these concerns.

Inspector #693 reviewed the CIS report and found that the report was amended on two different dates. The report identified that the RPN was off work and returned to work on a

particular date, and on this date a meeting would be held. There were no statements on the report that indicated the current status of the resident.

During an interview with the DOC, they indicated that the outcome and current status of the resident was not included on the report or amended reports.

Sources: Critical Incident System report, investigation file, interview with the DOC, interview with the resident; an employee file, the home's policy Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect, the home's policy Zero Tolerance of Abuse and Neglect of Residents, and the home's policy Critical Incident Reporting Requirement. [s. 104. (1) 3.]

2. The licensee has failed to include the outcome in making a report to the Director under subsection 23(2) of the Act, with respect to the alleged, suspected or witnessed incident of abuse of a resident.

Inspector #577 reviewed a CIS report and found that the report indicated that an RPN was placed on a leave pending the investigation. The report did not indicate any amendments made that indicated whether the allegation was founded or unfounded.

A review of the home’s policy, "Mandatory Reporting Requirements - LTC-20-05" effective October 2019, indicated that the licensee must report to the Director the results of the investigation and the actions taken. The report must be in writing and include the outcome or current status of the individual(s) who were involved in the incident.

During an interview with the Director of Care, together with Inspector #577, reviewed the CIS report. They confirmed that there wasn’t an amendment made that indicated whether that the allegation was founded or unfounded and the outcome indicated “pending investigation”.

Sources: Critical Incident System report, progress notes, investigation notes, the home’s policy Mandatory Reporting Requirements, and interviews with the DOC and other staff. [s. 104. (1) 3.]

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 in making a report to the Director under subsection 23 (2) of the Act, with respect to alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report, the outcome shall be included, to be implemented voluntarily.

WN #10: 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, that was reported to the licensee, was immediately investigated, with respect to a resident.

A CIS report was submitted to the Director regarding an allegation of verbal abuse by an RPN.

A review of the CIS report, as well as the home’s investigation notes, identified that the DOC began investigating this incident eight days later.

During an interview with the DOC, they indicated that they did not immediately investigate the allegations made by the resident because the RPN was on vacation, but that they should have started their investigation immediately.

Sources: Critical Incident System report, investigation file, interviews with the DOC and other staff, interview with the resident, the home's policy Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect. [s. 23. (1) (a)]

Issued on this 30th day of November, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577), MELISSA HAMILTON (693)
Inspection No. / No de l'inspection :	2020_633577_0021
Log No. / No de registre :	011004-20, 013209-20, 015938-20, 016059-20, 017841-20, 018860-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 16, 2020
Licensee / Titulaire de permis :	Nipigon District Memorial Hospital 125 Hogan Road, NIPIGON, ON, P0T-2J0
LTC Home / Foyer de SLD :	Nipigon District Memorial Hospital 125 Hogan Road, P.O. Box 37, NIPIGON, ON, P0T-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy Covino

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of of the Long-Term Care Homes Act, 2007.
Specifically the licensee must:
- Follow Directive #3 issued by the Chief Medical Officer of Health (CMOH)
- Ensure all staff and essential visitors in the long term care home wear surgical/procedure masks at all times, except during breaks, for as long as the Directive remains in effect

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

The Chief Medical Officer of Health (CMOH) issued Directive #3 on September 9, 2020, which required long-term care homes to immediately implement active screening of all staff, visitors and anyone else entering the home for COVID-19. Anyone showing symptoms of COVID-19 must not be allowed to enter the home and that all staff wear surgical/procedure masks at all times.

On a day in October 2020, Inspector #577 observed a staff member on the long term care unit walking around the nursing station without a surgical/procedure mask.

On another day in October 2020, Inspector #577 observed another staff member without a surgical/procedure mask, walking through the resident's hallway adjacent to the resident rooms.

On that same day, Inspector #577 observed another staff member standing at

the nursing station, and walking around the nursing station without a surgical/procedure mask.

During an interview with the RN/Quality Assurance and Infection Control, they advised that they had been instructed by the Infection Control Manager that they didn't need to don a mask as long as they maintained a two meter distance and spent a limited amount of time on the unit.

A review of the home's policies "Universal Mask Use in Health Care Settings and Long Term Care (COVID-19) – 5-45", effective August 5, 2020, and "Management Guidelines for Covid-19 in Long Term Care – LTC-2-02", effective September 30, 2020, indicated that all staff were required to wear a surgical/procedure mask at all times. During breaks staff could remove their mask but must remain two meters away from other staff to prevent staff to staff transmission of COVID-19. Universal masking of staff and essential visitors was intended to reduce the risk of transmitting COVID-19 from staff or essential visitors to residents or other staff. Essential visitors included a person performing essential support services (food delivery, phlebotomy testing, maintenance, and other health care services required to maintain good health).

Sources: the home's policies Universal Mask Use in Health Care Settings and Long Term Care COVID-19, and Management Guidelines for Covid-19 in Long Term Care, observations of staff and interviews with the DOC and other staff. [s. 5.]

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

Severity: There was an actual risk of harm to the residents, as all the direct care staff on the long term care side were wearing masks.

Scope: The scope of this non-compliance was widespread as it affected all residents.

Compliance history: One voluntary plan of correction (VPC) was issued to the home related to s. 5 in the past 36 months. (577)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Nov 23, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with s. 6 (10) b of the Long-Term Care Homes Act, 2007.
Specifically, the licensee must
- ensure a resident's care plan is updated to include fall prevention interventions
- ensure a resident's care plan is updated to exclude a particular restraint
- implement an auditing process which is completed by registered nursing staff and/or management staff, to ensure all resident care plans are being reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.
- perform weekly audits of resident's plans of care to ensure staff are reviewing and revising when the resident's care needs change or care set out in the plan is no longer necessary; and
-document the audits and continue auditing until 30 consecutive days of adherence is achieved.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised at least every six months, and at any other time when the resident's care needs change or care set out in the plan was no longer necessary, with respect to falls interventions.

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

incident that caused injury to a resident, for which the resident was taken to the hospital and resulted in a significant change in the resident's health status.

Inspector #693 reviewed the resident's electronic health records and identified that the resident was assessed as being a high fall risk on a specific assessment. The Inspector reviewed the resident's plans of care that were in effect over a specified time period, and identified that there was no focus specific to falls, as well as no falls prevention interventions for the resident.

During an interview with the DOC, they indicated that when the resident was assessed as a high falls risk, their care plan should have been updated to include a focus specific to falls, as well as falls prevention interventions. Additionally, the DOC indicated that after the resident fell, their care plan should have been updated to reflect the resident's care needs.

Sources:Critical Incident System report, the home's investigation file, resident's medical record; resident's care plans, the home's policy Admission to Long Term Care, the home's policy Falls Prevention and Management, interviews with the DOC and other staff. [s. 6. (10) (b)]

(693)

2. The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised at least every six months, and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary, with respect to restraints.

During an interview with the LTC Lead they identified that a resident had two unwitnessed falls on two days in October 2020.

Inspector #693 reviewed the resident's current care plan, which indicated that the resident utilized a particular intervention, at all times, when in bed.

During an Interview with the DOC, they indicated that this intervention was removed months ago when the resident transitioned to a long-term care resident. The DOC indicated that the care plan should have been revised and updated when the intervention was removed, to meet the resident's current care

needs.

Sources: resident's medical record, resident's care plan, the home's policy Admission to Long Term Care, interviews with the DOC and other staff. [s. 6. (10) (b)]

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

Severity: There was minimal risk of harm to two residents.

Scope: The scope of this non-compliance was a pattern, as it affected two residents.

Compliance history: A voluntary plan of correction (VPC) was issued to the home related to s. 6 (10)b in the past 36 months.
(693)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 11, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 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. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with s. 20. (1) of Ontario Regulation 79/10 Specifically the licensee must:

- Ensure that a resident is protected from abuse by a particular RPN
- Ensure a resident is protected from abuse by a particular PSW and a particular RPN
- Ensure a resident is protected from abuse by a particular RPN
- Ensure two residents are protected from abuse by a particular PSW
- Retrain all direct care staff, registered staff and leadership, on the long term care home's policy to promote zero tolerance of abuse and neglect of residents.
- Maintain records of training
- Develop and implement a system to monitor compliance with the home's abuse and neglect policies

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with, in respect to physical abuse of a resident.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

During an interview with an RPN, they advised Inspector #577 that a resident reported to them that an RPN was inappropriate with their transfers, verbally

abusive and belittling, it had been going on for a long time, and they were afraid when they arrived on their shift. They further advised that they reported this to the DOC four days later.

A review of home's policy, "Zero Tolerance of Abuse and Neglect of Residents - LTC-20-01", effective October 2019, indicated that all residents had the right to live in a home environment that treated them with dignity, respect and was free from any form of abuse or neglect at all times, and in all circumstances. They were committed to ensuring that the residents were protected from abuse and would ensure they were not neglected by the licensee or staff. It was the expectation that their employees protected their residents from abuse and neglect by anyone. A staff member was guilty of an offense if they failed to fulfill their legal obligation to make a report for alleged, suspected or witnessed abuse and neglect of a resident to the Administrator.

A review of the investigation file indicated that the resident stated they felt abused by the RPN; the RPN failed to have followed the home's Zero Tolerance of Abuse and Neglect policy; another RPN notified the DOC four days later after the resident told them that the RPN physically abused them, was inappropriate with their transfers and the resident felt too afraid to come forward; an email from the Administrator that indicated a conversation where the RPN confirmed that they were inappropriate when assisting the resident with a particular care activity and they had not denied the allegation.

During an interview with the resident, they reported to Inspector #577 that there were three incidents when the RPN handled them inappropriately during a particular care activity; reported that on the third incident, the RPN picked them up from their bed and 'plunked' them onto a specific apparatus and they experienced pain to an area of their body. Reported that they told the RPN that they wanted to walk to the bathroom and the RPN insisted that they used a specific apparatus. They further reported that they felt scared everytime they were on shift because of the way they treated them and felt it was abuse. They further advised that they had told another RPN about the RPN being inappropriate with a particular care activity.

During an interview with the DOC, they advised that they determined physical abuse of the resident by the RPN, and staff didn't follow the abuse policy as the

other RPN failed to immediately report the allegation made by the resident, until four days later.

Sources: Critical Incident System report, progress notes, investigation notes, the home's Zero Tolerance of Abuse and Neglect of Residents, and interviews with an RPN and other staff. [s. 20. (1)]
(577)

2. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with, in respect to verbal abuse of a resident.

According to the Long-Term Care Homes Act, 2007 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".

A review of the home's policy, "Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect - LTC-20-03", effective October 2019, indicated that their employees had an obligation to protect their residents from abuse by anyone, ensure that they were not neglected by the licensee or staff and report any alleged, suspected or witnessed abuse or neglect. All staff were required to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect, at the time of a witnessed or alleged incident, to the Administrator of the home. The Administrator must investigate immediately all reports of abuse or neglect.

A review of the CIS report indicated that a resident reported that a PSW often yelled at them to get up at particular times when they were not ready or did not want to get up. They also reported that they've heard them yell at another resident and ignore particular needs of another resident. The resident voiced concerns of retaliation from the PSW if they were made aware of them being reported by the resident.

A review of the investigation notes revealed an interview with the Activity Coordinator and the DOC. The notes indicated that the Activity Coordinator

reported that the PSW was often spoke to residents in a particular way.

During an interview with the resident, they advised Inspector #577 that the PSW yelled at them to get out of bed at particular times and yelled at two other residents.

During an interview with the DOC, they advised Inspector #577 that they determined verbal abuse by the PSW towards three residents.

Sources: Critical Incident System report, progress notes, investigation notes, the home's policy Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect, and interviews with the DOC and other staff. [s. 20. (1)]
(577)

3. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with, in respect to verbal abuse of a resident.

A CIS report was submitted to the Director regarding an allegation of verbal abuse by an RPN. The report indicated that a resident reported to the Administrator that they overheard an RPN yelling a particular statement at another resident in the hallway, as well that the RPN had made a particular statement towards them. The report indicated that the resident had expressed concerns of suffering repercussions if the RPN knew they were raising these concerns.

During an interview with the DOC they indicated that the RPN's actions toward the resident and the other resident constituted verbal abuse as per the legislation, and that their actions did not comply with the home's abuse policy.

Sources: Critical Incident System report, investigation file, interviews with the DOC and other staff, interview with the resident, an employee file, the home's policy Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect, the home's policy Zero Tolerance of Abuse and Neglect of Residents, the home's policy Professional Standards of Behaviour and the home's policy Code of Conduct. [s. 20. (1)]

(693)

4. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with, in respect to verbal abuse of a resident.

O. Reg. 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A CIS report was submitted to the Director for an allegation of emotional abuse. The CIS report indicated that the LTC Lead reported to the DOC that a resident's family member had reported to them, that an RPN made particular statements towards a resident in a stern, abrupt and derogatory voice. The resident's family member reported that the resident had indicated that they were made to feel as though they were in a prison.

The home's investigation notes included documentation of an interview that the DOC had with the resident that indicated that the resident had indicated that the RPN was very upset and made a particular statement towards them.

During an interview with the DOC they indicated that the RPN's actions toward the resident constituted emotional abuse as per the legislation and that their actions did not comply with the home's abuse policy.

Sources: Critical Incident System report, investigation file, interviews with the DOC and other staff, interview with the resident, resident's care plan, progress notes, the home's policy Zero Tolerance of Abuse and Neglect of Residents. [s. 20. (1)]

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

Severity: There was actual risk of harm as a resident had experienced pain and felt afraid; a resident felt like they were in prison; and residents experienced emotional, verbal and physical abuse.

Scope: The scope of this non-compliance was widespread as it affected five residents.

Compliance history: The licensee was found to be non-compliant with different sections of the legislation in the last 36 months. (693)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 14, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 004

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

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, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Order / Ordre :

The licensee must comply with s. 24. (1) 2 of Ontario Regulation 79/10.

Specifically, the licensee must prepare, submit and implement a plan to ensure that any suspected abuse and/or neglect, improper/incompetent care of a resident by the licensee or staff is reported immediately. The plan must include but is not limited to:
-What steps the home will undertake to address fear and retaliation in the home, concerning residents and staff.
-What steps the home will undertake to ensure that staff understand and comply with mandatory reporting of abuse and neglect.

Please submit the written plan for achieving compliance for inspection 2020_633577_0021 to Debbie Warpula, LTC Homes Inspector, MLTC, by email to sudburySAO.moh@ontario.ca by November 27, 2020.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds

to suspect that abuse of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A review of the home's policy, "Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect - LTC-20-03", effective October 2019, indicated that all staff were required to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect, at the time of a witnessed or alleged incident, to the Administrator of the home.

During an interview with an RPN they advised Inspector #577 that a resident reported to them that an RPN was inappropriate with a particular care activity, verbally abusive and belittling, it had been going on for a long time, and they were afraid when they arrived on their shift. They further advised that they reported this to the DOC four days later; they acknowledged that it should have been reported immediately and that they were afraid of the repercussions of reporting this against the RPN and what could potentially happen to them; they stated that it was not easy reporting a co-worker and they were afraid of repercussions and/or retaliation against themselves for reporting.

During an interview with the resident, they reported to Inspector #577 that they had told an RPN about another RPN being inappropriate with a particular care activity.

During an interview with the Activity Coordinator, they advised Inspector #577 that the resident had told them that they wanted to make a complaint about an RPN handling them a particular way. They reported to the Inspector that they didn't report it and the resident later told them that they reported it to an RPN.

A review of the investigation notes indicated that the resident told an RPN that the physical abuse by another RPN had been going on for awhile and the resident felt too afraid to report it.

During an interview with the DOC, they advised that the RPN had not followed the abuse policy as they didn't immediately report the allegation made by the

resident, until four days later.

b) During an interview with an RPN, they advised Inspector #577 that the resident had told them that an RPN had been withholding a particular medication. They further advised that another RPN overheard the conversation between the resident and themselves, and an RPN reported this information to the RPN. The RPN stated that they had not reported this allegation made by the resident. They advised that another RPN disclosed the allegation to the RPN.

A review of the investigation file revealed that an RPN reported to the DOC that another RPN had told them that they overheard the resident tell them that they had been withholding medication from the resident.

During an interview with the DOC, they advised that both RPNs should have reported the resident's allegation immediately.

Sources: two Critical Incident System reports, progress notes, investigation notes, the home's policy Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect, employee files, interview with the resident, interviews with an RPN and other staff. [s. 24. (1) 2.]

(577)

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director regarding an allegation of verbal abuse by an RPN towards a resident.

During an interview with the DOC, they indicated that this allegation of verbal abuse was not immediately reported to the Director and should have been.

Sources: Critical Incident System report, investigation file, interviews with the DOC and other staff, interview with a resident, the home's policy Reporting,

Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect. [s. 24. (1) 2.] (577)

3. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director for an allegation of emotional abuse.

A review of the home's investigation file identified a document composed by the LTC Lead which indicated that a resident's family member reported the allegation of emotional abuse to the LTC Lead.

During an interview with the DOC they indicated they when they had learned of the allegation of emotional abuse of the resident, they should have reported it to the Director then, as well that the LTC Lead should have reported the incident to management when they had received the allegation.

Sources: Critical Incident System report, investigation file, interviews with the DOC and other staff, interview with a resident, the home's policy Reporting, Notifying and Investigating Alleged, Suspected or Witnessed Incidents of Abuse or Neglect, the home's policy Zero Tolerance of Abuse and Neglect of Residents. [s. 24. (1) 2.]

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

Severity: There was actual risk of harm as a resident had experienced pain, felt afraid, it wasn't reported until four days later and three staff had not immediately reported allegations of abuse; the resident expressed fear in reporting abuse; a staff member expressed fear of repercussions toward the alleged abuser and fear of retaliation for reporting abuse; a resident felt like they were in prison and two staff members had not immediately reported the incident; and a resident expressed fear of retaliation for reporting abuse.

Scope: The scope of this non-compliance was widespread as it affected four

residents and four staff had not immediately reported allegations of abuse.

Compliance history: One compliance order (CO) was issued to the home related to s. 24 (1) in the past 36 months. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 27, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee must be compliant with r. 30. (1) of Ontario Regulation 79/10 Specifically the licensee must:

- Revise the home's Fall's Prevention Program, to ensure that it is congruent with Best Practices related to falls and post fall assessments; specifically related to unwitnessed and witnessed falls, including vital signs, neurological assessments, pain assessments and changes in cognitive status
- Ensure the program includes it's goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required
- Maintain a record of the retraining, what the training entailed, who completed the training and when the training was completed.
- Conduct a knowledge audit of their staff's understanding of falls management best practices and policy/program.

Grounds / Motifs :

1. The licensee has failed to ensure that the following was complied with in respect to each of the organized programs required under section 8 to 16 of the Act, and each of the interdisciplinary programs required under section 48 of Ontario Regulation 79/10.

Specifically, the licensee has failed to ensure that the Falls Prevention and Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A Critical Incident System (CIS) report was submitted to the Director for an incident that caused injury to a resident.

Inspector #693 reviewed the home's policy, "Falls Prevention and Management, NUR 101", revised July 2017. There was no indication in the policy, for a post falls assessment instrument to be completed, or for an HIR to be implemented longer than 28 hours post fall; as well no indication of monitoring vital signs, or monitoring for changes in behaviour for any witnessed falls without suspected head injury, and no indication to complete pain assessments after a fall, of any kind.

During an interview with the DOC, they indicated that the home's Falls program needed to be updated and revised to include current evidence-based practices, including a post falls assessment.

Sources: the home's policy Falls Prevention and Management, interviews with the DOC and other staff. [s. 30. (1) 1.]

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

Severity: There was minimal risk of harm to a resident.

Scope: The scope of this non-compliance was widespread, as it affected three residents who had falls.

Compliance history: The licensee was found to be non-compliant with different sections of the legislation in the last 36 months. (693)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 08, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36. of Ontario Regulation 79/10 Specifically, the licensee must

- Ensure that staff use safe transferring and positioning devices or techniques, when transferring a resident

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident from their bed to their commode.

The home's policy, "Patient Transfers using Transfer Tree – NUR- 54", effective March 2014, indicated that staff were to assess a resident's knee strength prior to assisting with a transfer, by having them extend one or both knees which determined if they could sustain gravity to stand. If the resident was unable, a mechanical lift was to be used.

The care plan for the resident indicated that they required a specified level of assistance with a particular care activity.

During an interview with an RPN they advised that the resident was assessed as requiring specific assistance with an activity. They stated that they recalled an incident where they had provided assistance and handled the resident in a particular way. They advised that after the activity, the resident complained of pain and that they should have requested a second staff member to assist them.

During an interview with the PT, they reported that staff should never provide

assistance in a particular way, and it was considered an unsafe.

Sources: Critical Incident System report, progress notes, investigation notes, the home's policy Patient Transfers using Transfer Tree, and interviews with the PT and other staff. [s. 36.] (577)

2. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident off the floor after a fall.

Inspector #693 reviewed the resident's medical record, related to a fall they sustained. The medical record included a specific report that indicated the resident was assisted in a particular way.

During an interview with the DOC, they indicated that the resident's care plan identified they were to always be assisted using a specific device after an incident. They advised that it was an improper intervention as the home's falls policy and patient transfers policy indicated that in this situation, a specific device should have been utilized with the assistance of two staff members, to complete the care activity of the resident.

Sources: resident's health record, progress notes, plan of care, the home's policy Falls Prevention and Management, the home's policy Patient Transfers Using Transfer Tree, interviews with the DOC and other staff. [s. 36.]

(693)

3. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

During an interview the LTC Lead identified that the resident sustained two unwitnessed falls on two days in October 2020.

Inspector #693 reviewed the resident's medical record, related to the falls they sustained. The medical record included a specific report for one of the resident's falls, that indicated the resident was assisted by a particular number of staff members, into their mobility aid.

During an interview with the DOC, they advised that this was an improper intervention as the home's falls policy and patient transfers policy indicated that in this situation a specific device should have been utilized with the assistance of two staff members, to complete care activity.

Sources: resident's health record, progress notes, plan of care, the home's policy Falls Prevention and Management, the home's policy Patient Transfers Using Transfer Tree, interviews with the DOC and other staff. [s. 36.]

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

Severity: There was actual risk of harm as a resident had experienced pain, and two residents weren't lifted with a mechanical lift post-fall.

Scope: The scope of this non-compliance was widespread, as it affected three residents.

Compliance history: The licensee was found to be non-compliant with different sections of the legislation in the last 36 months.
(693)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 23, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must be compliant with r. 48 (1) 1 of the Ontario Regulation 79/10 Specifically the licensee must:

- ensure that for any resident that has an un-witnessed fall with a head injury or suspected head injury, and witnessed fall with head injury, staff assess neurological vitals signs, vital signs, pain, bruising, and change in functional and cognitive status for 72 hours
- ensure that three resident's care plan interventions are updated after each fall, as the Falls Program requires

Grounds / Motifs :

1. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home, with respect to a resident's fall.

A Critical Incident System (CIS) report was submitted to the Director for a fall that caused injury to a resident, for which the resident was taken to the hospital

and resulted in a significant change in the resident’s health status. The report further identified that it was an unwitnessed fall, and the resident had sustained an injury.

Inspector #693 reviewed the progress notes for the resident and identified that the resident sustained two unwitnessed falls.

During an interview with the DOC, they indicated that a specific report was only completed for one of the falls, and should have been completed for both falls, as well, a specific routine should have been completed for both falls, which included specific monitoring for a particular number of hours, but was only started for one fall and not completed in full, and for the other fall not implemented. In addition, the DOC indicated that a specific risk assessment should have been completed after each fall and was not. The DOC indicated that another specific assessment was not completed for either fall.

Sources: Critical Incident System report, investigation file, resident’s medical record, resident’s plan of care, the home's Falls Prevention and Management, interviews with the DOC and other staff. [s. 48. (1) 1.]
(693)

2. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home, with respect to a resident's fall.

During an interview the LTC Lead identified that the resident sustained a fall and suffered an injury.

During an interview with the DOC, they indicated that the resident’s fall was witnessed by staff.

The DOC stated that the home’s falls management program was not implemented for the resident’s fall as a specific routine was not completed in full for a number of required hours and their care plan wasn't updated. The DOC indicated that a specific assessment was not completed after the fall.

Sources: resident’s health record, progress notes, plan of care, the home's

policy Falls Prevention and Management, interviews with the DOC and other staff. [s. 48. (1) 1.]
(693)

3. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home, with respect to a resident's fall.

During an interview, the LTC Lead identified that the resident sustained two unwitnessed falls on two separate days.

During an interview with the DOC, they indicated that both of the resident's falls were unwitnessed. The DOC advised that the home's falls management program was not implemented for the resident's fall as a specific routine was not completed for either fall, a specific risk assessment was not saved in MED e-care after each fall, and the resident's care plan was not updated, as the program had required. The DOC indicated that a specific assessment was not completed after either fall.

Sources: resident's health record, progress notes, plan of care, the home's policy Falls Prevention and Management, interviews with the DOC and other staff. [s. 48. (1) 1.]

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

Severity: There was actual risk of harm. A resident was injured and experienced a significant change in their health condition; a resident had a head injury and a head injury routine wasn't completed; a resident had two un-witnessed falls and a head injury routine wasn't completed.

Scope: The scope of this non-compliance was widespread, as it affected three residents.

Compliance history: The licensee was found to be non-compliant with different sections of the legislation in the last 36 months.
(693)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Nov 30, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Order / Ordre :

The licensee must be compliant with r. 114. (3) of the Ontario Regulation 79/10 Specifically the licensee must:

- re-educate an RPN on the home's High Risk Medication policy
- re-educate an RPN on the home's Medication Administration policy

Grounds / Motifs :

1. The licensee has failed to ensure that the written medication management policies and protocols were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, with respect to two residents.

Specifically, staff did not comply with the licensee's policies regarding "Medication Administration -5.1" and "High Alert/Risk Medications and/or Medication Administration Situations – NUR – 132".

The College of Nurses of Ontario Practice Standard, titled, 'Medication-2019', indicated that nurses promoted safe care, and contributed to a culture of safety within their practice environments, when involved in medication practices.

a) During an observation of a medication pass, Inspector #577 observed an RPN prepare and administer a particular medication to a resident, without a

second registered staff performing an independent double check. During an interview with the RPN, they advised that they should have called a registered staff member from the acute care side to double check the medication.

A review of the home's policy, "High Alert/Risk Medications and/or Medication Administration Situations – NUR – 132", effective April 2017, indicated that the particular medication was considered a high alert medication and all high alert medications required an independent double check.

During an interview with the DOC, they advised that the RPN had not followed the medication policy.

b) A review of the home's investigation file indicated that a resident had reported to an RPN that another RPN had been withholding a particular scheduled medication. The results of the investigation determined that the RPN had been administering a resident's three scheduled medications at a particular time; they were not following the home's policy in regards to Standard Administration Times, and the incident was a medication incident.

A review of the home's policy, "Medication Administration -5.1", effective March 2020, indicated that the home would establish a standard schedule of medication administration times based on the resident needs and characteristics of the medication regimen; medications were to be given within one hour of the scheduled administration time.

During an interview with the RPN, they advised that they had administered a resident's three scheduled medications at a particular time, and one of the medications was administered outside the one hour window.

During an interview with DOC, they advised that their investigation determined that the RPN was administering one of the resident's scheduled medication outside the one hour window and it was a medication incident.

Sources: Critical Incident System report, progress notes, investigation notes, the home's policy High Alert/Risk Medications and/or Medication Administration Situations, the home's policy Medication Administration, and interviews with an RPN and other staff. [s. 114. (3) (a)]

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

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

Severity: There was minimal risk of harm as a resident received their medication and a resident had no adverse effects after receiving a particular medication.

Scope: The scope of this non-compliance was a pattern, as it affected two residents.

Compliance history: The licensee was found to be non-compliant with different sections of the legislation in the last 36 months.

(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 23, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 16th day of November, 2020

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