Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 28, 2016	2015_283544_0023	011396-15	Follow up

Licensee/Titulaire de permis

WIKWEMIKONG NURSING HOME LIMITED
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

WIKWEMIKONG NURSING HOME
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

FRANCA MCMILLAN (544)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 14, 15, 16, 2015. Included in this inspection are several logs related to resident to resident abuse, staff to resident abuse and neglect and a complaint regarding the care of a resident.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Staff, Personal Support Workers (PSWs), Residents and Families.

The Inspector also reviewed residents' health care records, various policies and procedures, medication administration records, risk management records and other records relevant to this inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 53. (4)	CO #006	2015_332575_0004	544
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #002	2015_332575_0004	544
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #004	2015_332575_0004	544
O.Reg 79/10 s. 8. (1)	CO #003	2015_332575_0004	544

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident # 015 was protected from abuse by resident # 016.

The home was previously issued a compliance order regarding LTCHA, 2007, S. O. 2007, c. 8, s. 19 (1), during inspection 2015_332575_0004(A2).

The order was to ensure that the home protected residents from abuse by anyone and that the residents were not neglected by the licensee or staff. The home was to be in compliance with this order on July 6, 2015.

A Critical Incident System (CIS) report was submitted by the home to the Director. to the Director. This report identified physical abuse by resident # 016 towards resident # 015. Resident # 015 reported to the staff that resident # 016 had hit them.

Physical abuse between residents is defined in the Long-Term Care Homes Act, 2007, in O Reg.79/10, as the use of physical force by a resident that causes physical injury to another resident.

During an interview with PSW # 108, the Inspector was told that resident # 015 had sustained an injury to their body as a result of this incident.

A previous CI report was submitted to the Director by the home which identified a physical altercation between resident # 016 and resident # 017 had occurred. The report indicated that the residents were found by staff hitting each other.

Inspector reviewed resident # 016's health care records and identified that the resident had a history of physically responsive behaviours.

A review of resident # 016's care plan identified that resident # 016's responsive behaviours and the triggers for the physically responsive behaviours were not identified. There were no focus, goals, or interventions identified to address their physically responsive behaviours. Also there were no focus, goals, or interventions in resident # 016's care plan that addressed their dementia.

Inspector interviewed RN # 114 who told the Inspector that resident # 016's physically responsive behaviours had worsened.

During an interview with the Administrator, RN # 112 and the DOC all confirmed that resident # 016 had been referred to Behavioural Support Ontario (BSO). However, the resident had not been re-referred to BSO after the resident began exhibiting increased physically responsive behaviours.

2. The licensee has failed to ensure that resident # 012 was not neglected by the licensee or staff.

Neglect is defined in the Long-Term Care Homes Act, 2007, in O. Reg. 79/10, as the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The Inspector conducted a telephone interview with resident # 012's family member. They told the Inspector that they found that the resident had sustained an injury. They stated that RN # 112 told them that resident # 012 had had a fall earlier that day. The family member also told the Inspector that they had requested that the resident's doctor be notified and that resident # 012 be assessed.

During the same interview the family member told the Inspector that resident # 012 was found on the floor in one of the rooms in the home. Resident # 012 had a sustained a an injury as a result of the unwitnessed fall. The family member also indicated that the staff neglected to initiate a head injury routine and contact the physician as requested.

The Inspector reviewed the home's policy "Section: 3, Resident Safety, Subsection 3.6, falls Prevention and Management", it identified the following:
-Evaluate and Monitor resident for 72 hours after the fall. This included vital signs, head injury or neuro-vital signs and changes in cognition

-investigate the fall circumstances
-record circumstances', resident outcome, and staff response

The Inspector reviewed resident # 012's health care record and found that the care plan, that was in place, indicated that staff were to conduct hourly safety checks for resident # 012. No documentation was found to support that these checks had been completed during this time.

Inspector reviewed resident # 012's progress notes which indicated the resident had had two other falls. Resident # 012's health care record identified that there was no head injury routine initiated for these falls. Resident # 012's health care record identified that head injury routine was initiated, after resident # 012 had a third fall, but there was no documentation to support that head injury routine was completed for the full 72 hours as required post fall.

In an interview with RN # 112 and RPN # 104, both staff members confirmed the above findings.

In an interview with the Administrator and the DOC, they confirmed that it was the home's expectation that the home's policy regarding falls should have been followed and head injury routine should have been completed for the above falls and was not. The DOC confirmed that staff neglected to initiate head injury routine for the falls and fully complete the head injury routine as per the home's policy.

3. A Critical Incident System (CIS) report was submitted to the Director by the home. This report identified neglect towards resident # 013 by staff.

According to the CI report, resident # 013, pulled the call bell for a PSW to assist them to the bathroom. PSW # 113 took them into the bathroom. The resident pulled the call bell again to go back to their bed. They waited for over 30 minutes and no one responded to the call bell. Resident # 013 transferred themselves back to their bed with difficulty.

Inspector reviewed resident # 013's health care record and found that they used a wheelchair to mobilize. A review of resident # 013's care plan indicated that they required the assistance of 1-2 staff to transfer when being toileted.

Inspector interviewed resident # 013, who told the Inspector that they felt neglected and humiliated as a result of staff not assisting them. They also told the Inspector that they

did not ring for assistance the rest of the night for fear of retaliation.

During an interview with the Administrator, RPN # 104, and the DOC all confirmed that the incident had occurred and that PSW #113 neglected to answer resident # 013's call bell. Furthermore, they confirmed that PSW # 113 could not be found in the resident care area at that time.

The Inspector asked the DOC and the Administrator if the PSW had been provided with orientation prior to caring for residents. The Administrator and the DOC confirmed there was no record on file whether or not PSW #113 had been provided orientation to the home prior to performing their duties. The home was also unable to provide documentation or confirm if PSW #113 had received abuse training in the home. The Administrator and DOC admitted to the Inspector that they should have followed up on this issue and they should have ensured that PSW # 113 was trained prior to beginning their duties.

4. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

A Critical Incident System (CIS) report was submitted to the Director by the home. This report identified multiple incidents of neglect, improper and incompetent care, by RN # 100, towards multiple residents, while on duty, over three evenings.

The inspector reviewed the CI report and the following was identified:
- RN # 100 was dispensing medications that were required to be given at 1700 hour medication pass at 2000 hours.
- RN # 100, administered medications late to seven residents. The medications were administered to the wrong residents.
- Medications were not administered to two residents as ordered by the physician.
- RPN # 104 witnessed and confirmed that RN # 100 used a container filled with water to "dip" a spoon in, to clean it, after administering medications to the residents. The same spoon was used to administer medications to several other residents.
- RN # 100 had difficulty loading and prepping insulin pens and using a thermometer properly, as witnessed and confirmed by RPN # 104.
- Controlled medications were not administered to two residents as ordered by the physician and were not signed for correctly by RN # 100.
- RN # 100 did not provide wound care to residents as ordered and did not use the correct products to complete wound care. RN # 100 did not administer pain medications

to the two residents before their dressing changes, as was ordered by the physician.
- RN # 100 did not provide care for a resident requiring oxygen monitoring and did not complete their oxygen saturation record as required.
- RN # 100 did not complete the treatment administration records (TARS) as required after completing wound care for the residents and documented the wound care dressing changes on the wrong resident's health care record.

Inspector reviewed the home's Abuse/Neglect Prevention Program Policy Section 3: Subsection: 3.2, Abuse and Neglect, revised December 11, 2014, which stated that it is mandatory for all staff, to report immediately, any suspected allegation of abuse or neglect to the supervisor, DOC or the Administrator.

Inspector interviewed RPN # 104, RPN # 107, RN # 117 and PSW # 108 who witnessed the above incidents and confirmed that they had occurred. RPN # 104 told the Inspector that when RN # 100 was questioned as to why they did not provide care to the residents as ordered, RN # 100 reported that they were too busy.

During an interview, the Administrator told the Inspector that these issues were not reported immediately to S # 101 by RPN # 104 and RPN # 107. The Administrator told the Inspector that the staff should have reported RN # 100's improper and incompetent care of residents immediately.

RPN # 104, RPN # 107, RN # 117 and PSW # 108 all had reasonable grounds to suspect neglect due to improper and incompetent treatment and care of residents by RN # 100, that resulted in harm and a risk of harm to the residents. The home's staff did not report the improper care immediately, as required by the home's abuse policy. RN # 100 continued to put residents at risk for another two days before being terminated. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home had previously received a compliance order in Inspection 2015_332575_0004 (A2).
The order was to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

1. Inspector reviewed Critical Incident (CI), submitted by the home as abuse, whereby, staff witnessed resident # 016 punch resident # 017. The Inspector reviewed the progress notes which indicated that resident # 017's sustained an injury as a result of this incident.

The incident was not immediately reported to the Director. In an interview, with the Inspector, this was confirmed by the Administrator.

2. Inspector reviewed a CI submitted by the home as abuse, related to staff having witnessed resident # 020 in a physical altercation with resident # 001. The Inspector reviewed the progress notes which indicated that resident # 001 sustained a slight injury as a result of this incident.

In an interview with the Inspector, the Administrator and the DOC confirmed that the incident was not immediately reported to the Director.

3. Inspector reviewed a Critical Incident submitted by the home that identified resident # 013 was neglected by a staff member who did not provide toileting assistance to resident # 013, when they required assistance.

Resident # 013 told the Inspector they felt neglected and humiliated. They also told the Inspector that they did not ring for assistance the rest of the night for fear of retaliation. Resident # 013 also told the inspector that they reported this incident to the charge nurse immediately who then reported the incident of neglect and resident # 013's fear of retaliation to S # 101.

The Critical Incident was not immediately reported to the Director. In an interview with the Inspector, the Administrator and S # 101 confirmed that the incident was not immediately reported to the Director.

4. Inspector reviewed a CI submitted by the home as improper and incompetent treatment of residents that resulted in harm and risk of harm to residents, related to improper care and neglect by a staff member to several residents in the home over a period of three days.

RPN # 104, RPN # 107, RN # 117 and PSW # 108 witnessed multiple incidents of neglect, improper and incompetent care being provided to residents by RN # 100 over the course of three evening shifts. They did not report these incidents to anyone for three days. As a result, the residents remained at risk and were harmed while being cared for by RN # 100.

The CI was not immediately submitted to the Director. In an interview with the Inspector, this was confirmed by the Administrator.

5. Inspector reviewed a CI submitted by the home as abuse, whereby, resident # 022 hit resident # 009. According to the CI, resident # 009 sustained an injury.

The incident was not immediately reported to the Director. In an interview with the Inspector, this was confirmed by the Administrator.

6. Inspector reviewed a Critical Incident. Resident # 001 kicked resident # 017. Inspector interviewed resident # 017 who told the Inspector they sustained a minor injury. They also told the Inspector they could not remember when they reported it to the Administrator but thought that it was one or two days later.

The incident was not reported immediately reported to the Director when the home was told of the incident by resident # 017.

In an interview with the Inspector, this was confirmed by the Administrator. [s. 24. (1)]

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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The home received a previous compliance order regarding O. Reg. 79/10, s.49 (2), under Inspection 2015_283544_0003 with a compliance date of March 20, 2015.

The order read that the licensee shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Inspector reviewed a complaint regarding the care that the home provided to resident # 012.

The Inspector interviewed the complainant who was a family member of resident #012. They told the Inspector that they had noted an injury on resident # 012's body. The complainant reported that, later that same evening, they called the home and was told by RN # 112 that resident # 012 had fallen earlier that day. During the same interview, the complainant told the Inspector that they felt there was a change in resident #012's health status.

Inspector reviewed resident # 012's health care record which indicated that resident # 012 was found on the floor in another room. There were no witnesses to the fall and the resident sustained an injury as noted in their progress notes.

The Inspector reviewed resident #012's health care record and identified that resident #012 had had three falls in total.

The Inspector reviewed resident #012's health care record and identified that there were no completed post fall assessments, using a clinically appropriate assessment instrument, that is specifically designed for falls, for resident # 012's falls.

The Inspector interviewed the Administrator and the DOC, who both said that the home did not use a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

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

Issued on this 10th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	FRANCA MCMILLAN (544)
Inspection No. / No de l'inspection :	2015_283544_0023
Log No. / Registre no:	011396-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 28, 2016
Licensee / Titulaire de permis :	WIKWEMIKONG NURSING HOME LIMITED 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
LTC Home / Foyer de SLD :	WIKWEMIKONG NURSING HOME 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cheryl Osawabine-Peltier

To WIKWEMIKONG NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_332575_0004, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.
This plan must include:

1) strategies developed so that all staff receive orientation and abuse training prior to beginning their duties and the orientation records are kept on file.

2) strategies regarding the monitoring of residents by staff to ensure that minor altercations do not escalate.

3) strategies regarding the education that staff will receive to ensure that staff consistently monitor resident to prevent altercations and how resident altercations will be managed.

4) an audit of resident altercations and interventions used to prevent further escalation resident altercations.

The plan must be submitted to: Inspector Franca McMillan
159 Cedar Street, Suite 403,
Sudbury, Ontario. P3E 6A5 or by fax to (705) 654-3133 by February 8, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that resident # 015 was protected from abuse by resident # 016.

The home was previously issued a compliance order regarding LTCHA, 2007, S. O. 2007, c. 8, s. 19 (1), during inspection 2015_332575_0004(A2).

The order was to ensure that the home protected residents from abuse by anyone and that the residents were not neglected by the licensee or staff. The home was to be in compliance with this order on July 6, 2015.

A Critical Incident System (CIS) report was submitted by the home to the Director. to the Director. This report identified physical abuse by resident # 016 towards resident # 015. Resident # 015 reported to the staff that resident # 016 had hit them.

Physical abuse between residents is defined in the Long-Term Care Homes Act, 2007, in O Reg.79/10, as the use of physical force by a resident that causes physical injury to another resident.

During an interview with PSW # 108, the Inspector was told that resident # 015 had sustained an injury to their body as a result of this incident.

A previous CI report was submitted to the Director by the home which identified a physical altercation between resident # 016 and resident # 017 had occurred. The report indicated that the residents were found by staff hitting each other.

Inspector reviewed resident # 016's health care records and identified that the resident had a history of physically responsive behaviours.

A review of resident # 016's care plan identified that resident # 016's responsive behaviours and the triggers for the physically responsive behaviours were not identified. There were no focus, goals, or interventions identified to address their physically responsive behaviours. Also there were no focus, goals, or interventions in resident # 016's care plan that addressed their dementia.

Inspector interviewed RN # 114 who told the Inspector that resident # 016's physically responsive behaviours had worsened.

During an interview with the Administrator, RN # 112 and the DOC all confirmed that resident # 016 had been referred to Behavioural Support Ontario (BSO). However, the resident had not been re-referred to BSO after the resident began

exhibiting increased physically responsive behaviours.

2. The licensee has failed to ensure that resident # 012 was not neglected by the licensee or staff.

Neglect is defined in the Long-Term Care Homes Act, 2007, in O. Reg. 79/10, as the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The Inspector conducted a telephone interview with resident # 012's family member. They told the Inspector that they found that the resident had sustained an injury. They stated that RN # 112 told them that resident # 012 had had a fall earlier that day. The family member also told the Inspector that they had requested that the resident's doctor be notified and that resident # 012 be assessed.

During the same interview the family member told the Inspector that resident # 012 was found on the floor in one of the rooms in the home. Resident # 012 had a sustained a an injury as a result of the unwitnessed fall. The family member also indicated that the staff neglected to initiate a head injury routine and contact the physician as requested.

The Inspector reviewed the home's policy "Section: 3, Resident Safety, Subsection 3.6, falls Prevention and Management", it identified the following:
-Evaluate and Monitor resident for 72 hours after the fall. This included vital signs, head injury or neuro-vital signs and changes in cognition
-investigate the fall circumstances
-record circumstances', resident outcome, and staff response

The Inspector reviewed resident # 012's health care record and found that the care plan, that was in place, indicated that staff were to conduct hourly safety checks for resident # 012. No documentation was found to support that these checks had been completed during this time.

Inspector reviewed resident # 012's progress notes which indicated the resident had had two other falls. Resident # 012's health care record identified that there was no head injury routine initiated for these falls. Resident # 012's health care

record identified that head injury routine was initiated, after resident # 012 had a third fall, but there was no documentation to support that head injury routine was completed for the full 72 hours as required post fall.

In an interview with RN # 112 and RPN # 104, both staff members confirmed the above findings.

In an interview with the Administrator and the DOC, they confirmed that it was the home's expectation that the home's policy regarding falls should have been followed and head injury routine should have been completed for the above falls and was not. The DOC confirmed that staff neglected to initiate head injury routine for the falls and fully complete the head injury routine as per the home's policy.

3. A Critical Incident System (CIS) report was submitted to the Director by the home. This report identified neglect towards resident # 013 by staff.

According to the CI report, resident # 013, pulled the call bell for a PSW to assist them to the bathroom. PSW # 113 took them into the bathroom. The resident pulled the call bell again to go back to their bed. They waited for over 30 minutes and no one responded to the call bell. Resident # 013 transferred themselves back to their bed with difficulty.

Inspector reviewed resident # 013's health care record and found that they used a wheelchair to mobilize. A review of resident # 013's care plan indicated that they required the assistance of 1-2 staff to transfer when being toileted.

Inspector interviewed resident # 013, who told the Inspector that they felt neglected and humiliated as a result of staff not assisting them. They also told the Inspector that they did not ring for assistance the rest of the night for fear of retaliation.

During an interview with the Administrator, RPN # 104, and the DOC all confirmed that the incident had occurred and that PSW #113 neglected to answer resident # 013's call bell. Furthermore, they confirmed that PSW # 113 could not be found in the resident care area at that time.

The Inspector asked the DOC and the Administrator if the PSW had been provided with orientation prior to caring for residents. The Administrator and the

DOC confirmed there was no record on file whether or not PSW #113 had been provided orientation to the home prior to performing their duties. The home was also unable to provide documentation or confirm if PSW #113 had received abuse training in the home. The Administrator and DOC admitted to the Inspector that they should have followed up on this issue and they should have ensured that PSW # 113 was trained prior to beginning their duties.

4. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

A Critical Incident System (CIS) report was submitted to the Director by the home. This report identified multiple incidents of neglect, improper and incompetent care, by RN # 100, towards multiple residents, while on duty, over three evenings.

The inspector reviewed the CI report and the following was identified:
- RN # 100 was dispensing medications that were required to be given at 1700 hour medication pass at 2000 hours.
- RN # 100, administered medications late to seven residents. The medications were administered to the wrong residents.
- Medications were not administered to two residents as ordered by the physician.
- RPN # 104 witnessed and confirmed that RN # 100 used a container filled with water to “dip” a spoon in, to clean it, after administering medications to the residents. The same spoon was used to administer medications to several other residents.
- RN # 100 had difficulty loading and prepping insulin pens and using a thermometer properly, as witnessed and confirmed by RPN # 104.
- Controlled medications were not administered to two residents as ordered by the physician and were not signed for correctly by RN # 100.
- RN # 100 did not provide wound care to residents as ordered and did not use the correct products to complete wound care. RN # 100 did not administer pain medications to the two residents before their dressing changes, as was ordered by the physician.
- RN # 100 did not provide care for a resident requiring oxygen monitoring and did not complete their oxygen saturation record as required.
- RN # 100 did not complete the treatment administration records (TARS) as required after completing wound care for the residents and documented the wound care dressing changes on the wrong resident’s health care record.

Inspector reviewed the home's Abuse/Neglect Prevention Program Policy Section 3: Subsection: 3.2, Abuse and Neglect, revised December 11, 2014, which stated that it is mandatory for all staff, to report immediately, any suspected allegation of abuse or neglect to the supervisor, DOC or the Administrator.

Inspector interviewed RPN # 104, RPN # 107, RN # 117 and PSW # 108 who witnessed the above incidents and confirmed that they had occurred. RPN # 104 told the Inspector that when RN # 100 was questioned as to why they did not provide care to the residents as ordered, RN # 100 reported that they were too busy.

During an interview, the Administrator told the Inspector that these issues were not reported immediately to S # 101 by RPN # 104 and RPN # 107. The Administrator told the Inspector that the staff should have reported RN # 100's improper and incompetent care of residents immediately.

RPN # 104, RPN # 107, RN # 117 and PSW # 108 all had reasonable grounds to suspect neglect due to improper and incompetent treatment and care of residents by RN # 100, that resulted in harm and a risk of harm to the residents. The home's staff did not report the improper care immediately, as required by the home's abuse policy. RN # 100 continued to put residents at risk for another two days before being terminated. [s. 19. (1)]

The scope of this issue is a pattern and there is ongoing non-compliance with a previous order given to the home under Inspection # 2015_332575_0004 (A2). The severity is determined as actual harm. This impacts negatively on the health, safety and well-being of the residents. (544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_332575_0004, CO #005;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

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 risk of harm to a resident.

The plan must include strategies that that will demonstrate how the home will educate staff, how and when to report critical incidents and how to complete the critical incident reports in as much detail as possible so that the critical incident report is complete.

The plan must be submitted to:
Inspector Franca McMillan
159 Cedar Street, Suite # 403,
Sudbury, Ontario. P3E 6A5 or by fax to (705) 564-3133 before February 8, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
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.

The home had previously received a compliance order in Inspection 2015_332575_0004 (A2). The order was to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

1. Inspector reviewed Critical Incident (CI), submitted by the home as abuse, whereby, staff witnessed resident # 016 punch resident # 017. The Inspector

reviewed the progress notes which indicated that resident # 017's sustained an injury as a result of this incident.

The incident was not immediately reported to the Director. In an interview, with the Inspector, this was confirmed by the Administrator.

2. Inspector reviewed a CI submitted by the home as abuse, related to staff having witnessed resident # 020 in a physical altercation with resident # 001. The Inspector reviewed the progress notes which indicated that resident # 001 sustained a slight injury as a result of this incident.

In an interview with the Inspector, the Administrator and the DOC confirmed that the incident was not immediately reported to the Director.

3. Inspector reviewed a Critical Incident submitted by the home that identified resident # 013 was neglected by a staff member who did not provide toileting assistance to resident # 013, when they required assistance.

Resident # 013 told the Inspector they felt neglected and humiliated. They also told the Inspector that they did not ring for assistance the rest of the night for fear of retaliation. Resident # 013 also told the inspector that they reported this incident to the charge nurse immediately who then reported the incident of neglect and resident # 013's fear of retaliation to S # 101.

The Critical Incident was not immediately reported to the Director. In an interview with the Inspector, the Administrator and S # 101 confirmed that the incident was not immediately reported to the Director.

4. Inspector reviewed a CI submitted by the home as improper and incompetent treatment of residents that resulted in harm and risk of harm to residents, related to improper care and neglect by a staff member to several residents in the home over a period of three days.

RPN # 104, RPN # 107, RN # 117 and PSW # 108 witnessed multiple incidents of neglect, improper and incompetent care being provided to residents by RN # 100 over the course of three evening shifts. They did not report these incidents to anyone for three days. As a result, the residents remained at risk and were harmed while being cared for by RN # 100.

The CI was not immediately submitted to the Director. In an interview with the Inspector, this was confirmed by the Administrator.

5. Inspector reviewed a CI submitted by the home as abuse, whereby, resident # 022 hit resident # 009. According to the CI, resident # 009 sustained an injury.

The incident was not immediately reported to the Director. In an interview with the Inspector, this was confirmed by the Administrator.

6. Inspector reviewed a Critical Incident. Resident # 001 kicked resident # 017. Inspector interviewed resident # 017 who told the Inspector they sustained a minor injury. They also told the Inspector they could not remember when they reported it to the Administrator but thought that it was one or two days later.

The incident was not reported immediately reported to the Director when the home was told of the incident by resident # 017.

In an interview with the Inspector, this was confirmed by the Administrator. [s. 24. (1)]

The scope of this issue is a pattern and there is ongoing non-compliance with a previous order given to the home under Inspection # 2015_332575_0004 (A2). The severity is determined minimal harm or potential for actual harm. This impacts negatively on the health, safety and well-being of the residents. (544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2016

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_283544_0003, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
The plan must include:

1) a clinically appropriate post fall assessment instrument specifically designed for falls.

2) provide training for all staff on how to use the instrument.

3) develop strategies to monitor and audit the use of the fall assessment instrument.

The plan must be submitted to:
Inspector Franca McMillan
159 Cedar Street, Suite 403,
Sudbury, Ontario. P3E 6A5 or by fax at (705) 564-3133 by February 8, 2016.

Grounds / Motifs :

1. 1. The licensee failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident

require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The home received a previous compliance order regarding O. Reg. 79/10, s.49 (2), under Inspection 2015_283544_0003 with a compliance date of March 20, 2015.

The order read that the licensee shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Inspector reviewed a complaint regarding the care that the home provided to resident # 012.

The Inspector interviewed the complainant who was a family member of resident #012. They told the Inspector that they had noted an injury on resident # 012's body. The complainant reported that, later that same evening, they called the home and was told by RN # 112 that resident # 012 had fallen earlier that day. During the same interview, the complainant told the Inspector that they felt there was a change in resident #012's health status.

Inspector reviewed resident # 012's health care record which indicated that resident # 012 was found on the floor in another room. There were no witnesses to the fall and the resident sustained an injury as noted in their progress notes.

The Inspector reviewed resident #012's health care record and identified that resident #012 had had three falls in total.

The Inspector reviewed resident #012's health care record and identified that there were no completed post fall assessments, using a clinically appropriate assessment instrument, that is specifically designed for falls, for resident # 012's falls.

The Inspector interviewed the Administrator and the DOC, who both said that the home did not use a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

The scope of this issue is a pattern and there is ongoing non-compliance with a

previous order given to the home under Inspection # 2015_332575_0004 (A2). The severity is determined as actual harm. This impacts negatively on the health, safety and well-being of the residents. (544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 28th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Franca McMillan

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