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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Oct 24, 2017;	2017_615638_0017 (A1)	017814-17, 017817-17, 017840-17, 017863-17, 017865-17, 021924-17	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

RYAN GOODMURPHY (638) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance due dates for compliance orders #001, #002, #003 and #005 amended to December 1, 2017.

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 24 day of October 2017 (A1)

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

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Ministère de la Santé et des Soins de longue durée

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

RYAN GOODMURPHY (638) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): September 5 - 8, and 13 - 14, 2017.

The following intakes were inspected in this Follow-Up inspection;

-One log was related to CO #001 from inspection report #2017_562620_0007, s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007, specific to the home's duty to protect the residents from abuse and neglect,

-One log was related to CO #002 from inspection report #2017_562620_0007, s. 24 (1) of the LTCHA, 2007, specific to reporting certain matters to the Director,

-One log was related to CO #003 from inspection report #2017_562620_0007, r. 30 (1) of the Ontario Regulation (O. Reg.) 79/10, specific to general requirements of the home and the required program evaluations,

-One log was related to CO #004 from inspection report #2017_562620_0007, r. 99 of the O. Reg. 79/10, specific to the evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents,

-One log was related to CO #005 from inspection report #2017_562620_0007, r. 15 (1) of the O. Reg. 79/10, specific to bed rails in the home and the system evaluation and,

-One log was related to CO #001 from inspection report #2017_572627_0015, s. 19 (1) of the LTCHA, 2017, specific to the home's duty to protect the residents from abuse and neglect.

A Critical Incident System (CIS) inspection #2017_615638_0016, and a Complaint inspection #2017_615638_0018, were conducted concurrently with this Follow-Up inspection. Findings from CIS inspection #2017_615638_0016, related to s. 24 (1), reporting certain matters to the Director and s. 19 (1), duty to protect residents from abuse have been included within this inspection report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Maintenance Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant internal investigation notes, licensee policies, procedures, programs and resident health care records.

Ad-hoc notes were used during this inspection.

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

- **5 WN(s)**
- **0 VPC(s)**
- **5 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

During inspection #2017_562620_0007, Compliance Order (CO) #005 was served to the licensee on June 28, 2017, related to the bed rail systems, which ordered the licensee to prepare, submit and implement a plan to ensure that where bed rails were used, the resident was assessed and their bed system evaluated. The plan was to have included;

"a) A detailed description of how the licensee will ensure that where bed systems fail the zone entrapment testing, interventions are put in place immediately to eliminate the risk to the resident.
b) The plan shall also include specified time frames for the development and implementation and identify the staff member (s) responsible for the implementation."

The plan was to be submitted by July 12, 2017, and be complied with by July 28, 2017.

Inspector #638, requested the completed records of the bed system entrapment testing, what the results where, which beds failed the testing and the corrective

action taken on September 6, 2017, and again on September 7, 2017.

In an interview with Inspector #638, the DOC stated they had requested the documentation from the Maintenance Manager, who informed the DOC that there was no record of any entrapment checks. The DOC also indicated that the home did not have the bed system evaluation tool to complete the entrapment checks.

The home's policy titled "Resident Services Manual – Section 3 Resident Safety" effective date July 2012, indicated that the home was required to establish a group to measure existing bed systems and take corrective actions as needed. The policy identified that the home was to assess the beds within the home to ensure that entrapment zones and risks were evaluated.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012, was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document referenced the 'Clinical Guidance for the Assessment and implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for assessing the use of bed rails. The memo informed all LTC homes that they were required to conduct assessments for zones of entrapment.

Inspector #638 interviewed the Maintenance Manager who indicated that none of the bed systems had been evaluated and that no corrective action had been taken as a result. The Maintenance Manager indicated that they had not obtained the bed system evaluation tool or developed a tracking tool for the bed system evaluations. The Inspector reviewed the best practice guidelines with the Maintenance Manager who indicated that they were unaware of the best practice guidelines and unaware of what was required in the bed entrapment checks. [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: 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

of each of the organized programs required under sections 8 to 16 of the Act and section 48 of the regulation; specifically, there was no written description of the program that included it's goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

During inspection #2017_562620_0007, CO #003 was served to the licensee on June 28, 2017, related to the organized programs required under section 8 to 16 of the Act and section 48 of the regulation. The CO had a compliance due date of August 28, 2017, and directed the home to;

"ensure that following program is be evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
a) Falls Prevention Program, ensuring that the program is consistent with O. Reg. 79/10, s. 49.,
b) Skin and Wound Care Program, ensuring that the program is consistent with O. Reg. 79/10, s. 50.,
c) Continence Care and Bowel Management Program, ensuring that the program is consistent with O. Reg. 79/10, s. 51., and
d) Nutrition and Hydration Program, ensuring that the program is consistent with O. Reg. 79/10, s. 68., and 69."

On September 5, 2017, Inspector #638 requested the evaluations and newly developed programs for the home's;
-Fall Prevention Program,
-Skin and Wound Care Program,
-Continence Care and Bowel Management Program, and
-Nutrition and Hydration Program.

In an interview with Inspector #638, the Administrator stated that in relation to the Fall Prevention Program, the Skin and Wound Care Program, the Continence Care and Bowel Management Program and the Nutrition and Hydration Program, that they were all currently being reviewed by the team leads. The Administrator stated that the reviews had not been completed and the newly revised programs had not been finalized or implemented into practice at this time.

During an interview with Inspector #638, the DOC indicated that they had started

their role as DOC on August 2, 2017. The DOC indicated that they had assumed the responsibility of the outstanding orders from inspection report #2017_562620_0007 and had not had the opportunity to review or finalize the program evaluations on the programs identified in CO #003 of the aforementioned inspection report. [s. 30. (1) 3.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee’s policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

During inspection #2017_562620_0007, CO #004 was served to the licensee on June 28, 2017, related to the evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents. The CO had a compliance due date of August 28, 2017, and ordered the licensee to ensure;

"(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it,
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences,
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation,
(d) that the changes and improvements under clause (b) are promptly implemented, and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared."

Inspector #638 requested the program evaluation and newly revised program for the home’s policy to promote zero tolerance of abuse and neglect of residents on September 5, 2017.

In an interview with Inspector #638, the Administrator stated that the policy to promote zero tolerance of abuse and neglect of residents was being reviewed by the team lead. The Administrator stated that the reviews had not been completed and the newly revised program to promote zero tolerance of abuse and neglect of residents, had not been completed or implemented into practice at the time.

During an interview with Inspector #638, the DOC indicated that they had started their role as DOC on August 2, 2017. The DOC indicated that they had assumed the responsibility of the outstanding orders and had not had the opportunity to review or finalize the program to promote zero tolerance of abuse and neglect of residents at the time of inspection. [s. 99.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 any resident was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

During inspection #2017_562620_0007, CO #001 was served to the licensee on June 28, 2017, related to the duty to protect any resident from abuse by anyone and from neglect by the licensee or staff in the home. The CO ordered the licensee to;

"a) ensure that residents are protected from abuse by anyone,
b) ensure that all incidents of suspected/actual abuse are immediately investigated, and
c) ensure that the home's newly evaluated, revised, and analyzed Policy on Zero Tolerance of Abuse and Neglect is complied with by all staff."

In relation to section "c)", Inspector #638 was unable to comply this section as the home had not completed the required evaluation of the home's policy of zero tolerance of abuse and neglect of residents as per CO #004 from inspection report #2017_562620_0007. Therefore, the staff were unable to comply with section "c)" requirements related to the newly evaluated, revised, and analyzed Policy on Zero Tolerance of Abuse and Neglect. Please refer to WN #3 for details regarding CO #004 from inspection report #2017_562620_0007. [s. 19. (1)]

2. On September 1, 2017, Inspector #627 conducted a CIS inspection (#2017_572627_0015). As a result of the inspection, an immediate order (CO #001) was served to the licensee related to s. 19 (1) of the LTCHA, 2007, on September 1, 2017, regarding the home's duty to protect any resident from abuse by resident #001. The immediate order, directed the licensee to "prepare, submit and implement a plan that requires one to one supervision of resident #001 at all times."

Inspector #638 followed up on the immediate order (CO #001) from inspection report #2017_572627_0015.

Inspector #638 reviewed the CIS report, submitted to the Director, which outlined an incident of suspected resident to resident physical abuse between resident #001 and resident #002. The incident caused injury to resident #002 for which they were taken to hospital.

Additional non compliances were identified by Inspector #638 in regards to resident #001's interventions to minimize the risk of future incidents, which had the potential to be ineffective in managing the physically responsive behaviours of resident #001.

a) Section 6 (9) 1. of the LTCHA, 2007, required that the provision of care set out in the plan of care was documented.

A CIS report was submitted to the Director, related to an incident of suspected

resident to resident abuse.

Inspector #638 reviewed resident #001's health care records and identified within their plan of care that at the time of inspection the resident had a specific intervention implemented which was initiated after the incident of suspected resident to resident abuse had occurred.

The Inspector reviewed the documentation record of the specific intervention for resident #001 over an eight day period. The Inspector identified that there were gaps in the documentation record of the specific intervention three of the eight days. On one date, the Inspector identified 15 occasions in which there was no documentation related to the resident's safety intervention. There was no documentation regarding the resident's specific intervention between 0645 hours and 1345 hours (seven hours) for the resident on the second date, and no documentation on the specific intervention between 1130 hours and 1345 hours on the third date.

Please refer to WN #1 finding "1." of inspection report #2017_615638_0016 for details.

b) Section 6 (10) of the LTCHA, 2007 required that the resident was reassessed and the plan of care 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.

During an observation of resident #001's room, Inspector #638 noted a specific intervention implemented in the resident's room.

Inspector #638 reviewed resident #001's health care records and identified in a progress note written by RPN #102 on a specific date in August, 2017, that the resident demonstrated specific responsive behaviours when other residents entered their room. The notation indicated that a specific intervention was implemented as a result. The Inspector reviewed resident #001's care plan and was unable to identify any indication that the resident required the specific intervention to minimize their risk of behaviours.

Please refer to WN #1 finding "2." of inspection report #2017_615638_0016 for details. [s. 19. (1)]

3. Emotional abuse is defined within the O.Reg 79/10. 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.

Verbal abuse is defined within the O.Reg 79/10. as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A CIS report was submitted to the Director on a specific date, which detailed an incident of witnessed verbal and emotional abuse towards resident #002 one week prior. The incident identified that on a specific date in August, 2017, the Administrator overheard RN #107 slam the nursing station door on resident #002 and the RN stated "leave me alone" and "I can't tolerate (resident #002)".

a) Inspector #638 reviewed the internal investigation notes of an interview held between the Administrator, DOC and RN #107 seven days after the incident. The interview notes indicated that RN #107 stated that they had shut the door on resident #002 at least twice. When questioned regarding what was said to the resident, the RN stated "I can't recall". The investigation notes identified that due to the severity of the incident as well as the witnessed events by the Administrator, they would be placed on a suspension.

Inspector #638 interviewed RN #107, who stated that they were working the night shift when the incident had occurred. They indicated that resident #002 and other residents were at the nurses station and were asking repetitive questions which did not allow them the opportunity to focus on their work. The RN indicated that they did close the door on the resident, however, they could not recall what they said to resident #002. The RN indicated that they were aware that their actions were not acceptable and they were placed on a suspension.

The home's policy titled "Section 3.2 Abuse and Neglect Prevention Program" last revised June 2015, indicated that the symptoms of psychosocial abuse included humiliation, dehumanization, verbal abuse, shouting, scolding.

In an interview with Inspector #638, the DOC indicated that they were notified at the time of the incident, by the Administrator, regarding an incident of abuse

involving resident #002 and RN #107 that the Administrator had overheard. The DOC indicated that when they had discussed the incident with RN #107 one week after the incident had occurred, the RN confirmed that they did slam a door in the resident's face, however, they could not recall what they said to the resident.

During an interview with Inspector #638, the Administrator indicated that they were in their office when the incident occurred. They indicated that they overheard RN #107 slamming the door in resident #002's face and stated that they heard the RN state "I can't tolerate" resident #002. The Administrator identified that this was considered a form of abuse.

The licensee failed to protect the residents by not complying with the following areas of legislation under the LTCHA, 2007; s. 23 (1) and s. 24 (1).

b) Section 23 (1) of the LTCHA, 2007 requires that every alleged, suspected or witnessed incident of abuse of a resident by anyone was immediately investigated.

In an interview with Inspector #638, RN #107 stated after the incident of alleged abuse on a specific date in August 2017, they worked their entire shift and finished a second shift prior to being approached by management to interview them regarding the incident (seven days after the incident of witnessed abuse).

The home's policy titled "Section 3.2 Abuse and Neglect Prevention Program" last revised June 2015, indicated that the procedure for investigating a resident abuse by formal caregiver, volunteer or visitor included that the investigation would have been immediately initiated and the suspected or accused staff member would be relieved from their duties with pay while the investigation was being conducted.

Inspector #638 reviewed the internal investigation notes, which identified that RN #107 was interviewed seven days after the incident of witnessed abuse by the Administrator.

The Inspector reviewed the home's active staff schedule and identified that RN #107 worked in the home as a registered staff member after the incident of abuse. The RN worked two full shifts after the incident of witnessed abuse, prior to their suspension.

In an interview with Inspector #638, the DOC indicated that whenever a staff member was suspected of abuse they would be put on a leave pending

investigation and the investigation would commence immediately. The DOC indicated that they had interviewed RN #107 regarding another incident two days after the alleged abuse, however, they did not discuss the incident of abuse witnessed by the Administrator, as they believed that because the Administrator witnessed the incident that they had already conducted the investigation. The DOC indicated RN #107 worked in the capacity of a registered staff member for two full shifts prior to being investigated regarding the incident of witnessed abuse.

Inspector #638 interviewed the Administrator who stated that they were leaving for the day when they overheard the incident between resident #002 and RN #107. They indicated that the RN had just initiated their medication pass and did not want to interrupt the pass. The Administrator had planned on coming back at a later time to discuss the incident with the RN, which did not occur. The Administrator indicated that RN #107's next shift was one week later and that they interviewed the RN at that the end of their shift on that shift. The Administrator indicated that any abuse should be investigated immediately.

c) Section 24 (1) of the LTCHA, 2007 requires any person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm to the resident was immediately be reported to the Director.

Inspector #638 reviewed a CIS report submitted on a specific date related to an incident of abuse the Administrator witnessed between RN #107 and resident #002. The CIS report indicated that the incident had occurred seven days prior to the submission of the CIS report.

The home's policy titled "Section 3.2 Abuse and Neglect Prevention Program" last revised June 2015, indicated that following an incident of abuse, the Administrator or designate would have notified the MOHLTC immediately via Critical Incident Reporting System, or via pager after hours.

Inspector #638 interviewed the DOC who indicated that they were made aware of the incident by the Administrator at the time of the incident, however, they were not directed to report the incident to the Director and believed that the Administrator had reported it because they had witnessed the incident.

In an interview with Inspector #638, the Administrator stated that they reported the incident seven days after witnessing the abuse. They indicated that any abuse

should be immediately reported to the Director, however, they did not do this on the date of the witnessed abuse between resident #002 and RN #107. [s. 19. (1)]

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During inspection #2017_562620_0007, CO #002 was served to the licensee on June 28, 2017, related to reporting certain matter to the Director. The CO had a compliance due date of July 7, 2017, and ordered the licensee to;

"ensure that any 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:
a) Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
b) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
c) Unlawful conduct that resulted in harm or a risk of harm to a resident.
d) Misuse or misappropriation of a resident's money."

Inspector #638 reviewed a CIS report submitted on a specific date related to an incident of abuse the Administrator witnessed between RN #107 and resident #002. The CIS report indicated that the incident had occurred seven days prior to the submission of the CIS report.

The home's policy titled "Section 3.2 Abuse and Neglect Prevention Program" last revised June 2015, indicated that following an incident of abuse, the Administrator or designate would have notified the MOHLTC immediately via Critical Incident Reporting System, or via pager after hours.

Inspector #638 interviewed the DOC who indicated that they were made aware of the incident by the Administrator at the time of the incident, however, they were not directed to report the incident to the Director and believed that the Administrator had reported it because they had witnessed the incident.

In an interview with Inspector #638, the Administrator stated that they reported the incident seven days after witnessing the abuse. They indicated that any abuse should be immediately reported to the Director, however, they did not do this on the

date of the witnessed abuse between resident #002 and RN #107. [s. 24. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 005

Issued on this 24 day of October 2017 (A1)

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

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : RYAN GOODMURPHY (638) - (A1)

Inspection No. / No de l'inspection : 2017_615638_0017 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 017814-17, 017817-17, 017840-17, 017863-17, 017865-17, 021924-17 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Oct 24, 2017;(A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_562620_0007, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall:

a) Ensure that where bed rails are used, the resident is assessed and their bed system is evaluated.

b) Obtain and utilize a bed entrapment tool to evaluate every bed systems where bed rails are used.

c) Develop and implement a process to ensure that a full bed rail entrapment assessment is completed for every bed system with bed rails in accordance with the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".

d) Maintain a record for each bed system evaluated, which includes; the zones of entrapment tested, what the results were, which bed systems failed the entrapment test and what actions or interventions put in place to immediately eliminate the risk to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

During inspection #2017_562620_0007, Compliance Order (CO) #005 was served to the licensee on June 28, 2017, related to the bed rail systems, which ordered the licensee to prepare, submit and implement a plan to ensure that where bed rails were used, the resident was assessed and their bed system evaluated. The plan was to have included;

"a) A detailed description of how the licensee will ensure that where bed systems fail the zone entrapment testing, interventions are put in place immediately to eliminate the risk to the resident.
b) The plan shall also include specified time frames for the development and implementation and identify the staff member (s) responsible for the implementation."

The plan was to be submitted by July 12, 2017, and be complied with by July 28, 2017.

Inspector #638, requested the completed records of the bed system entrapment testing, what the results where, which beds failed the testing and the corrective action taken on September 6, 2017, and again on September 7, 2017.

In an interview with Inspector #638, the DOC stated they had requested the documentation from the Maintenance Manager, who informed the DOC that there was no record of any entrapment checks. The DOC also indicated that the home did not have the bed system evaluation tool to complete the entrapment checks.

The home's policy titled "Resident Services Manual – Section 3 Resident Safety" effective date July 2012, indicated that the home was required to establish a group to measure existing bed systems and take corrective actions as needed. The policy identified that the home was to assess the beds within the home to ensure that entrapment zones and risks were evaluated.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012, was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document referenced the 'Clinical Guidance for the Assessment and implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for assessing the use of bed rails. The memo informed all LTC homes that they were required to conduct assessments for zones of entrapment.

Inspector #638 interviewed the Maintenance Manager who indicated that none of the bed systems had been evaluated and that no corrective action had been taken as a result. The Maintenance Manager indicated that they had not obtained the bed system evaluation tool or developed a tracking tool for the bed system evaluations. The Inspector reviewed the best practice guidelines with the Maintenance Manager who indicated that they were unaware of the best practice guidelines and unaware of what was required in the bed entrapment checks.

During a previous inspections (#2015_332575_0004 and #2017_562620_0007) a Written Notification (WN) was issued to the home on May 25, 2015, and a CO was served to the home on June 28, 2017, related to the Ontario Regulation (O. Reg) 79/10, s. 15 (1). The decision to re-issue this CO was based on the severity which

indicates the risk of actual harm to the residents. The scope had the potential to impact all the residents who use bed rails, which included a compliance history including one ongoing CO related to this section of the legislation. (638)

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

Dec 01, 2017(A1)

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2017_562620_0007, CO #003;

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 shall ensure that following programs are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

a) Falls Prevention Program, ensuring that the program is consistent with O. Reg. 79/10, s. 49.,

b) Skin and Wound Care Program, ensuring that the program is consistent with
O. Reg. 79/10, s. 50.,

c) Continence Care and Bowel Management Program, ensuring that the program is consistent with O. Reg. 79/10, s. 51., and

d) Nutrition and Hydration Program, ensuring that the program is consistent with
O. Reg. 79/10, s. 68., and 69.

Grounds / Motifs :

1. The licensee has failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and section 48 of the regulation; specifically, there was no written description of the program that included it's goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

During inspection #2017_562620_0007, CO #003 was served to the licensee on June 28, 2017, related to the organized programs required under section 8 to 16 of the Act and section 48 of the regulation. The CO had a compliance due date of August 28, 2017, and directed the home to;

"ensure that following program is be evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
a) Falls Prevention Program, ensuring that the program is consistent with O. Reg. 79/10, s. 49.,
b) Skin and Wound Care Program, ensuring that the program is consistent with O.

Reg. 79/10, s. 50.,
c) Continence Care and Bowel Management Program, ensuring that the program is consistent with O. Reg. 79/10, s. 51., and
d) Nutrition and Hydration Program, ensuring that the program is consistent with O. Reg. 79/10, s. 68., and 69."

On September 5, 2017, Inspector #638 requested the evaluations and newly developed programs for the home's;
-Fall Prevention Program,
-Skin and Wound Care Program,
-Continence Care and Bowel Management Program, and
-Nutrition and Hydration Program.

In an interview with Inspector #638, the Administrator stated that in relation to the Fall Prevention Program, the Skin and Wound Care Program, the Continence Care and Bowel Management Program and the Nutrition and Hydration Program, that they were all currently being reviewed by the team leads. The Administrator stated that the reviews had not been completed and the newly revised programs had not been finalized or implemented into practice at this time.

During an interview with Inspector #638, the DOC indicated that they had started their role as DOC on August 2, 2017. The DOC indicated that they had assumed the responsibility of the outstanding orders from inspection report #2017_562620_0007 and had not had the opportunity to review or finalize the program evaluations on the programs identified in CO #003 of the aforementioned inspection report.

During a previous inspection (#2017_562620_0007) a CO was served to the home on June 28, 2017, related to the O. Reg 79/10, s. 30 (1). The decision to re-issue this CO was based on the severity which indicates a minimal risk of harm to the residents. The scope had the potential to impact all the residents of the home, which included a compliance history including one ongoing CO related to this section of the legislation. (638)

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

Dec 01, 2017(A1)

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

Ministère 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 : 003

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

Linked to Existing Order / Lien vers ordre existant: 2017_562620_0007, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 99. Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Order / Ordre :

The licensee shall:

a) Ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it.

b) Ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

c) Ensure that the results of the analysis undertaken under clause (a) are considered in the evaluation.

d) Ensure that the changes and improvements under clause (b) are promptly implemented.

e) Ensure that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

Grounds / Motifs :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

During inspection #2017_562620_0007, CO #004 was served to the licensee on June 28, 2017, related to the evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents. The CO had a compliance due date of August 28, 2017, and ordered the licensee to ensure;

"(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it,
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements

are required to prevent further occurrences,
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation,
(d) that the changes and improvements under clause (b) are promptly implemented, and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared."

Inspector #638 requested the program evaluation and newly revised program for the home's policy to promote zero tolerance of abuse and neglect of residents on September 5, 2017.

In an interview with Inspector #638, the Administrator stated that the policy to promote zero tolerance of abuse and neglect of residents was being reviewed by the team lead. The Administrator stated that the reviews had not been completed and the newly revised program to promote zero tolerance of abuse and neglect of residents, had not been completed or implemented into practice at the time.

During an interview with Inspector #638, the DOC indicated that they had started their role as DOC on August 2, 2017. The DOC indicated that they had assumed the responsibility of the outstanding orders and had not had the opportunity to review or finalize the program to promote zero tolerance of abuse and neglect of residents at the time of inspection.

During a previous inspection (#2017_562620_0007) a CO was served to the home on June 28, 2017, related to the O. Reg 79/10, s. 99. The decision to re-issue this CO was based on the severity which indicates a minimal risk of harm to the residents. The scope had the potential to impact all the residents of the home, which included a compliance history including one ongoing CO related to this section of the legislation. (638)

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

Dec 01, 2017(A1)

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

Ministère 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 : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Ensure that all resident's of the home are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

b) Ensure that all incidents of suspected, alleged or witnessed abuse are immediately investigated.

c) Retrain all direct care staff (PSWs, RPNs and RNs) and management on the home's policy of Zero Tolerance of Abuse and Neglect to ensure all incidents of suspected, alleged or witnessed abuse are managed as per the home's policy.

Grounds / Motifs :

1. The licensee has failed to ensure that any resident was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

During inspection #2017_562620_0007, CO #001 was served to the licensee on

June 28, 2017, related to the duty to protect any resident from abuse by anyone and from neglect by the licensee or staff in the home. The CO ordered the licensee to;

"a) ensure that residents are protected from abuse by anyone,
b) ensure that all incidents of suspected/actual abuse are immediately investigated, and
c) ensure that the home's newly evaluated, revised, and analyzed Policy on Zero Tolerance of Abuse and Neglect is complied with by all staff."

In relation to section "c)", Inspector #638 was unable to comply this section as the home had not completed the required evaluation of the home's policy of zero tolerance of abuse and neglect of residents as per CO #004 from inspection report #2017_562620_0007. Therefore, the staff were unable to comply with section "c)" requirements related to the newly evaluated, revised, and analyzed Policy on Zero Tolerance of Abuse and Neglect. Please refer to WN #3 for details regarding CO #004 from inspection report #2017_562620_0007.

2. On September 1, 2017, Inspector #627 conducted a CIS inspection (#2017_572627_0015). As a result of the inspection, an immediate order (CO #001) was served to the licensee related to s. 19 (1) of the LTCHA, 2007, on September 1, 2017, regarding the home's duty to protect any resident from abuse by resident #001. The immediate order, directed the licensee to "prepare, submit and implement a plan that requires one to one supervision of resident #001 at all times."

Inspector #638 followed up on the immediate order (CO #001) from inspection report #2017_572627_0015.

Inspector #638 reviewed the CIS report, submitted to the Director, which outlined an incident of suspected resident to resident physical abuse between resident #001 and resident #002. The incident caused injury to resident #002 for which they were taken to hospital.

Additional non compliances were identified by Inspector #638 in regards to resident #001's interventions to minimize the risk of future incidents, which had the potential to be ineffective in managing the physically responsive behaviours of resident #001.

a) Section 6 (9) 1. of the LTCHA, 2007, required that the provision of care set out in the plan of care was documented.

A CIS report was submitted to the Director, related to an incident of suspected resident to resident abuse.

Inspector #638 reviewed resident #001's health care records and identified within their plan of care that at the time of inspection the resident had a specific intervention implemented which was initiated after the incident of suspected resident to resident abuse had occurred.

The Inspector reviewed the documentation record of the specific intervention for resident #001 over an eight day period. The Inspector identified that there were gaps in the documentation record of the specific intervention three of the eight days. On one date, the Inspector identified 15 occasions in which there was no documentation related to the resident's safety intervention. There was no documentation regarding the resident's specific intervention between 0645 hours and 1345 hours (seven hours) for the resident on the second date, and no documentation on the specific intervention between 1130 hours and 1345 hours on the third date.

Please refer to WN #1 finding "1." of inspection report #2017_615638_0016 for details.

b) Section 6 (10) of the LTCHA, 2007 required that the resident was reassessed and the plan of care 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.

During an observation of resident #001's room, Inspector #638 noted a specific intervention implemented in the resident's room.

Inspector #638 reviewed resident #001's health care records and identified in a progress note written by RPN #102 on a specific date in August, 2017, that the resident demonstrated specific responsive behaviours when other residents entered their room. The notation indicated that a specific intervention was implemented as a result. The Inspector reviewed resident #001's care plan and was unable to identify any indication that the resident required the specific intervention to minimize their risk of behaviours.

Please refer to WN #1 finding "2." of inspection report #2017_615638_0016 for

details. [s. 19. (1)]

3. Emotional abuse is defined within the O.Reg 79/10. 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.

Verbal abuse is defined within the O.Reg 79/10. as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A CIS report was submitted to the Director on a specific date, which detailed an incident of witnessed verbal and emotional abuse towards resident #002 one week prior. The incident identified that on a specific date in August, 2017, the Administrator overheard RN #107 slam the nursing station door on resident #002 and the RN stated "leave me alone" and "I can't tolerate (resident #002)".

a) Inspector #638 reviewed the internal investigation notes of an interview held between the Administrator, DOC and RN #107 seven days after the incident. The interview notes indicated that RN #107 stated that they had shut the door on resident #002 at least twice. When questioned regarding what was said to the resident, the RN stated "I can't recall". The investigation notes identified that due to the severity of the incident as well as the witnessed events by the Administrator, they would be placed on a suspension.

Inspector #638 interviewed RN #107, who stated that they were working the night shift when the incident had occurred. They indicated that resident #002 and other residents were at the nurses station and were asking repetitive questions which did not allow them the opportunity to focus on their work. The RN indicated that they did close the door on the resident, however, they could not recall what they said to resident #002. The RN indicated that they were aware that their actions were not acceptable and they were placed on a suspension.

The home's policy titled "Section 3.2 Abuse and Neglect Prevention Program" last revised June 2015, indicated that the symptoms of psychosocial abuse included humiliation, dehumanization, verbal abuse, shouting, scolding.

In an interview with Inspector #638, the DOC indicated that they were notified at the time of the incident, by the Administrator, regarding an incident of abuse involving resident #002 and RN #107 that the Administrator had overheard. The DOC indicated that when they had discussed the incident with RN #107 one week after the incident had occurred, the RN confirmed that they did slam a door in the resident's face, however, they could not recall what they said to the resident.

During an interview with Inspector #638, the Administrator indicated that they were in their office when the incident occurred. They indicated that they overheard RN #107 slamming the door in resident #002's face and stated that they heard the RN state "I can't tolerate" resident #002. The Administrator identified that this was considered a form of abuse.

The licensee failed to protect the residents by not complying with the following areas of legislation under the LTCHA, 2007; s. 23 (1) and s. 24 (1).

b) Section 23 (1) of the LTCHA, 2007 requires that every alleged, suspected or witnessed incident of abuse of a resident by anyone was immediately investigated.

In an interview with Inspector #638, RN #107 stated after the incident of alleged abuse on a specific date in August 2017, they worked their entire shift and finished a second shift prior to being approached by management to interview them regarding the incident (seven days after the incident of witnessed abuse).

The home's policy titled "Section 3.2 Abuse and Neglect Prevention Program" last revised June 2015, indicated that the procedure for investigating a resident abuse by formal caregiver, volunteer or visitor included that the investigation would have been immediately initiated and the suspected or accused staff member would be relieved from their duties with pay while the investigation was being conducted.

Inspector #638 reviewed the internal investigation notes, which identified that RN #107 was interviewed seven days after the incident of witnessed abuse by the Administrator.

The Inspector reviewed the home's active staff schedule and identified that RN #107 worked in the home as a registered staff member after the incident of abuse. The RN worked two full shifts after the incident of witnessed abuse, prior to their suspension.

In an interview with Inspector #638, the DOC indicated that whenever a staff member was suspected of abuse they would be put on a leave pending investigation and the investigation would commence immediately. The DOC indicated that they had interviewed RN #107 regarding another incident two days after the alleged abuse, however, they did not discuss the incident of abuse witnessed by the Administrator, as they believed that because the Administrator witnessed the incident that they had already conducted the investigation. The DOC indicated RN #107 worked in the capacity of a registered staff member for two full shifts prior to being investigated regarding the incident of witnessed abuse.

Inspector #638 interviewed the Administrator who stated that they were leaving for the day when they overheard the incident between resident #002 and RN #107. They indicated that the RN had just initiated their medication pass and did not want to interrupt the pass. The Administrator had planned on coming back at a later time to discuss the incident with the RN, which did not occur. The Administrator indicated that RN #107's next shift was one week later and that they interviewed the RN at that the end of their shift on that shift. The Administrator indicated that any abuse should be investigated immediately.

c) Section 24 (1) of the LTCHA, 2007 requires any person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm to the resident was immediately be reported to the Director.

Inspector #638 reviewed a CIS report submitted on a specific date related to an incident of abuse the Administrator witnessed between RN #107 and resident #002. The CIS report indicated that the incident had occurred seven days prior to the submission of the CIS report.

The home's policy titled "Section 3.2 Abuse and Neglect Prevention Program" last revised June 2015, indicated that following an incident of abuse, the Administrator or designate would have notified the MOHLTC immediately via Critical Incident Reporting System, or via pager after hours.

Inspector #638 interviewed the DOC who indicated that they were made aware of the incident by the Administrator at the time of the incident, however, they were not directed to report the incident to the Director and believed that the Administrator had reported it because they had witnessed the incident.

In an interview with Inspector #638, the Administrator stated that they reported the incident seven days after witnessing the abuse. They indicated that any abuse should be immediately reported to the Director, however, they did not do this on the date of the witnessed abuse between resident #002 and RN #107.

During a previous inspection (#2017_562620_0007) a CO was served to the home on June 28, 2017, related to the Long-Term Care Homes Act (LTCHA), 2007, s. 19 (1). The decision to re-issue this CO was based on the severity which indicates the risk of actual harm to the residents. The scope had the potential to impact the fewest number of residents and included a compliance history including one ongoing CO related to this section of the legislation. (638)

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

Nov 01, 2017

Order # /
Ordre no : 005

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

Linked to Existing Order /
Lien vers ordre existant: 2017_562620_0007, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

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

During inspection #2017_562620_0007, CO #002 was served to the licensee on June 28, 2017, related to reporting certain matter to the Director. The CO had a compliance due date of July 7, 2017, and ordered the licensee to;

"ensure that any 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:
a) Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
b) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

c) Unlawful conduct that resulted in harm or a risk of harm to a resident.
d) Misuse or misappropriation of a resident's money."

Inspector #638 reviewed a CIS report submitted on a specific date related to an incident of abuse the Administrator witnessed between RN #107 and resident #002. The CIS report indicated that the incident had occurred seven days prior to the submission of the CIS report.

The home's policy titled "Section 3.2 Abuse and Neglect Prevention Program" last revised June 2015, indicated that following an incident of abuse, the Administrator or designate would have notified the MOHLTC immediately via Critical Incident Reporting System, or via pager after hours.

Inspector #638 interviewed the DOC who indicated that they were made aware of the incident by the Administrator at the time of the incident, however, they were not directed to report the incident to the Director and believed that the Administrator had reported it because they had witnessed the incident.

In an interview with Inspector #638, the Administrator stated that they reported the incident seven days after witnessing the abuse. They indicated that any abuse should be immediately reported to the Director, however, they did not do this on the date of the witnessed abuse between resident #002 and RN #107.

During a previous inspections (#2016_395613_0003 and #2017_562620_0007) a Voluntary Plan of Correction (VPC) was issued to the home on May 19, 2016, and a CO was served to the home on June 28, 2017, related to the LTCHA, 2007, s. 24 (1). The decision to re-issue this CO was based on the severity which indicates minimal risk of harm to the residents. The scope had the potential to impact the residents on a widespread level and included a compliance history including one ongoing CO related to this section of the legislation. (638)

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

Dec 01, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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

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

Health Services Appeal and Review Board and the Director

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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 24 day of October 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RYAN GOODMURPHY

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

Service Area Office / Bureau régional de services : Sudbury