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

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) :	MELISSA CHISHOLM (188)
Inspection No. / No de l'inspection :	2013_099188_0013
Log No. / Registre no:	S-000102-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 25, 2013
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 :	~~ELIZABETH COOPER~~ me Hali Pitwawankwat (acting)

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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 26. (1) No person shall retaliate against another person, whether by action or omission, or threaten to do so because,
(a) anything has been disclosed to an inspector;
(b) anything has been disclosed to the Director including, without limiting the generality of the foregoing,
(i) a report has been made under section 24, or the Director has otherwise been advised of anything mentioned in paragraphs 1 to 5 of subsection 24 (1),
(ii) the Director has been advised of a breach of a requirement under this Act, or
(iii) the Director has been advised of any other matter concerning the care of a resident or the operation of a long-term care home that the person advising believes ought to be reported to the Director; or
(c) evidence has been or may be given in a proceeding, including a proceeding in respect of the enforcement of this Act or the regulations, or in an inquest under the Coroners Act. 2007, c. 8, s. 26 (1).

Order / Ordre :

The Licensee shall ensure that all staff members at the home receive training and/or retraining on the whistleblower protections in s. 26 of the LTCHA.

Grounds / Motifs :

1. Based on the following findings the licensee through the Administrator/Director of Care retaliated against staff members #100 and #101.

Two staff members, staff #100 and staff #101, contacted the Director through the Actionline and reported complaints related to the operation of the home, resident care and potential resident abuse. An anonymous complaint inspection was conducted February 27-28 and March 1, 2013 related to these complaints. Findings of non-compliance were issued to the licensee. During this complaint inspection the identity of the complainants was not released by the inspector, however the Administrator/Director of Care (Admin/DOC) verbally reported to

the inspector her belief that she knew the identity of one of the complainants and named staff #101. The inspector did not engage in discussion related to the identity of the complainants thus was unsure how the Admin/DOC became aware of this information.

On March 4, 2013, the inspector was contacted by complainants #100 and #101 who identified they had fewer scheduled shifts than previously. The two staff members identified at that time a belief that the reduction in scheduled shifts was related to the Admin/DOC knowing they had brought forward complaints to the Director. The two staff members were never provided any explanation for the reduction in scheduled work hours by the Admin/DOC.

On March 5, 2013, staff #100 went on a medical leave and was no longer working in the home.

The staff members #100 and #101 continued to communicate with the inspector. They identified they had contacted the Ministry of Labour and had plans to attend a board meeting to bring forward additional complaints which they felt the Admin/DOC was not responding to appropriately.

On March 13-14, 2013 the Ministry of Labour conducted an inspection and a report with findings was issued to the licensee.

On March 20, 2013 staff member #100 and #101 attended a board meeting at the home along with two other employees and two former employees. All six individuals presented their complaints to the board. Staff #100 and #101 submitted their concerns in writing and provided a copy of these written complaints to the inspector following the meeting.

On March 26, 2013 the Sudbury Service Area Manager received an email from the Admin/DOC related to the group of individuals that presented complaints to the board on March 20, 2013. Although the email did not specifically name staff members, it did identify two personal support workers, one who's husband worked in the dietary department and was let go. Further, the email identifies these staff members attended the board meeting on March 20, 2013 and submitted written letters of complaint. This leads one to conclude that the Admin/DOC is referring to staff #100 and #101. This email identifies the Admin/DOC's understanding that these individuals brought complaints forward

to the Director, the Ministry of Labour and to the Board of Directors for the home. The Admin/DOC articulated her disapproval as these staff members had ignored internal processes for complaints and further the Admin/DOC identified this type of behaviour would not be accepted or condoned.

On March 27, 2013 staff #101's employment was terminated by the Admin/DOC. The letter of termination stated "wilful misconduct and disobedience" as the cause for termination. No further written explanation was written and no verbal communication was provided to staff #101 related to the termination. This was confirmed by both the Admin/DOC and staff #101 during interviews with the inspector.

On April 2, 2013 staff #101 was served with a no trespass order. It was reported by the Admin/DOC to be related to an incident involving staff #101's husband and another staff member which took place at the grocery store. However, no clear understanding as to why staff #101 was served with the no trespass order from the home was ever provided.

Also on April 2, 2013, staff member #100 received a termination letter via registered mail (staff #100 had been on medical leave and not worked in the home since March 5, 2013). The cause for termination was also "wilful misconduct and disobedience" without any further explanation. She was not contacted by the Admin/DOC who signed and sent the letter. The letter was dated March 27, 2013 (same date that staff #101 was terminated).

On April 3, 2013 staff #100 attended a follow-up board meeting and made an appeal for her employment to be reinstated. Direction from the Board of Directors to the Admin/DOC in a copy of the minutes, which was shared with the ministry by the Admin/DOC, was to reinstate staff #100. Staff #100 received a phone call from the Admin/DOC on April 4, 2013 identifying her job was reinstated and she could return to work once her medical leave was completed. No written confirmation of this was ever received by staff #100 from the Admin/DOC. Attempts to contact the Admin/DOC by staff #100 following the initial conversation on April 4, 2013 were unsuccessful.

On April 16, 2013 staff #100 also received a no trespass order from the home. This was received via registered mail, and did not include any explanation or rationale for the order. Staff #100 had been verbally informed her job was

reinstated then served a no trespass order for an unknown reason.

The on-site inspection into the allegations of retaliation began on April 16, 2013 and was conducted by inspectors #188 and #212.

Inspector #188 reviewed the personnel files of the two terminated employees. Aside from a copy of the termination letter no additional documentation was contained within the files related to the cause for termination. Further, inspector noted no disciplinary documents were found within the files. Inspector spoke with the Admin/DOC who confirmed no discipline had previously been issued to either employee and no documentation related to the cause for termination was available. The Admin/DOC confirmed that neither employee had received a performance review during their employment at the home. The Admin/DOC had verbally informed inspectors about concerns with these employees, however acknowledged she had never formally approached these employees to discuss the concerns regarding their performance. The only documents contained within the files related to payroll and employee health benefits.

During the interview with the inspector the Admin/DOC identified that although she was never directly informed by the two staff members that they had gone to the Director with concerns she had heard from various staff members within the home that the complaints to the Director originated from them.

On April 18, 2013 the Admin/DOC was provided written discipline for failure to reinstate terminated staff member #100 as per the direction of the Board of Directors. The written discipline summarizes staff #100's termination as retaliation.

The Admin/DOC terminated staff #100 and #101 following their attendance at a board meeting on March 20, 2013 where they presented complaints to the board. The Admin/DOC confirmed that there was no previous discipline to either employee and the inspectors found nothing documented to support termination within staff #100 or #101's personnel files. (188)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 26, 2013

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.

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

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 25th day of June, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MELISSA CHISHOLM

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 25, 2013	2013_099188_0013	S-000102-13	Complaint

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 16-17, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the staff members who alleged retaliation, and a staff member who brought forward concerns to the Board of Management.

During the course of the inspection, the inspector(s) reviewed personnel files for terminated employees, reviewed letters of complaint received by the Board of Management, reviewed the written response composed by the Administrator/Director of Care and reviewed various other documents as provided to the inspector by the complainants or the Administrator/Director of Care.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 26. Whistle-blowing protection

Specifically failed to comply with the following:

s. 26. (1) No person shall retaliate against another person, whether by action or omission, or threaten to do so because,
(a) anything has been disclosed to an inspector; 2007, c. 8, s. 26 (1).
(b) anything has been disclosed to the Director including, without limiting the generality of the foregoing,
(i) a report has been made under section 24, or the Director has otherwise been advised of anything mentioned in paragraphs 1 to 5 of subsection 24 (1),
(ii) the Director has been advised of a breach of a requirement under this Act, or
(iii) the Director has been advised of any other matter concerning the care of a resident or the operation of a long-term care home that the person advising believes ought to be reported to the Director; or 2007, c. 8, s. 26 (1).
(c) evidence has been or may be given in a proceeding, including a proceeding in respect of the enforcement of this Act or the regulations, or in an inquest under the Coroners Act. 2007, c. 8, s. 26 (1).

Findings/Faits saillants :

1. Based on the following findings the licensee through the Administrator/Director of Care retaliated against staff members #100 and #101.

Two staff members, staff #100 and staff #101, contacted the Director through the Actionline and reported complaints related to the operation of the home, resident care and potential resident abuse. An anonymous complaint inspection was conducted February 27-28 and March 1, 2013 related to these complaints. Findings of non-compliance were issued to the licensee. During this complaint inspection the identity of the complainants was not released by the inspector, however the Administrator/Director of Care (Admin/DOC) verbally reported to the inspector her belief that she knew the identity of one of the complainants and named staff #101. The inspector did not engage in discussion related to the identity of the complainants thus was unsure how the Admin/DOC became aware of this information.

On March 4, 2013, the inspector was contacted by complainants #100 and #101 who identified they had fewer scheduled shifts than previously. The two staff members identified at that time a belief that the reduction in scheduled shifts was related to the Admin/DOC knowing they had brought forward complaints to the Director. The two staff members were never provided any explanation for the reduction in scheduled work hours by the Admin/DOC.

On March 5, 2013, staff #100 went on a medical leave and was no longer working in the home.

The staff members #100 and #101 continued to communicate with the inspector. They identified they had contacted the Ministry of Labour and had plans to attend a board meeting to bring forward additional complaints which they felt the Admin/DOC was not responding to appropriately.

On March 13-14, 2013 the Ministry of Labour conducted an inspection and a report with findings was issued to the licensee.

On March 20, 2013 staff member #100 and #101 attended a board meeting at the home along with two other employees and two former employees. All six individuals presented their complaints to the board. Staff #100 and #101 submitted their concerns in writing and provided a copy of these written complaints to the inspector following the meeting.

On March 26, 2013 the Sudbury Service Area Manager received an email from the Admin/DOC related to the group of individuals that presented complaints to the board on March 20, 2013. Although the email did not specifically name staff members, it did identify two personal support workers, one who's husband worked in the dietary department and was let go. Further, the email identifies these staff members attended the board meeting on March 20, 2013 and submitted written letters of complaint. This leads one to conclude that the Admin/DOC is referring to staff #100 and #101. This email identifies the Admin/DOC's understanding that these individuals brought complaints forward to the Director, the Ministry of Labour and to the Board of Directors for the home. The Admin/DOC articulated her disapproval as these staff members had ignored internal processes for complaints and further the Admin/DOC identified this type of behaviour would not be accepted or condoned.

On March 27, 2013 staff #101's employment was terminated by the Admin/DOC. The letter of termination stated "wilful misconduct and disobedience" as the cause for termination. No further written explanation was written and no verbal communication was provided to staff #101 related to the termination. This was confirmed by both the Admin/DOC and staff #101 during interviews with the inspector.

On April 2, 2013 staff #101 was served with a no trespass order. It was reported by the Admin/DOC to be related to an incident involving staff #101's husband and another staff member which took place at the grocery store. However, no clear understanding as to why staff #101 was served with the no trespass order from the home was ever provided.

Also on April 2, 2013, staff member #100 received a termination letter via registered mail (staff #100 had been on medical leave and not worked in the home since March 5, 2013). The cause for termination was also "wilful misconduct and disobedience" without any further explanation. She was not contacted by the Admin/DOC who signed and sent the letter. The letter was dated March 27, 2013 (same date that staff #101 was terminated).

On April 3, 2013 staff #100 attended a follow-up board meeting and made an appeal for her employment to be reinstated. Direction from the Board of Directors to the Admin/DOC in a copy of the minutes, which was shared with the ministry by the Admin/DOC, was to reinstate staff #100. Staff #100 received a phone call from the

Admin/DOC on April 4, 2013 identifying her job was reinstated and she could return to work once her medical leave was completed. No written confirmation of this was ever received by staff #100 from the Admin/DOC. Attempts to contact the Admin/DOC by staff #100 following the initial conversation on April 4, 2013 were unsuccessful.

On April 16, 2013 staff #100 also received a no trespass order from the home. This was received via registered mail, and did not include any explanation or rationale for the order. Staff #100 had been verbally informed her job was reinstated then served a no trespass order for an unknown reason.

The on-site inspection into the allegations of retaliation began on April 16, 2013 and was conducted by inspectors #188 and #212.

Inspector #188 reviewed the personnel files of the two terminated employees. Aside from a copy of the termination letter no additional documentation was contained within the files related to the cause for termination. Further, inspector noted no disciplinary documents were found within the files. Inspector spoke with the Admin/DOC who confirmed no discipline had previously been issued to either employee and no documentation related to the cause for termination was available. The Admin/DOC confirmed that neither employee had received a performance review during their employment at the home. The Admin/DOC had verbally informed inspectors about concerns with these employees, however acknowledged she had never formally approached these employees to discuss the concerns regarding their performance. The only documents contained within the files related to payroll and employee health benefits.

During the interview with the inspector the Admin/DOC identified that although she was never directly informed by the two staff members that they had gone to the Director with concerns she had heard from various staff members within the home that the complaints to the Director originated from them.

On April 18, 2013 the Admin/DOC was provided written discipline for failure to reinstate terminated staff member #100 as per the direction of the Board of Directors. The written discipline summarizes staff #100's termination as retaliation.

The Admin/DOC terminated staff #100 and #101 following their attendance at a board meeting on March 20, 2013 where they presented complaints to the board. The

Admin/DOC confirmed that there was no previous discipline to either employee and the inspectors found nothing documented to support termination within staff #100 or #101's personnel files. [s. 26. (1) (a)]

Additional Required Actions:

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

Issued on this 27th day of June, 2013

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