Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur 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
Aug 20, 2019	2019_740621_0024	009347-19	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street THUNDER BAY ON P7B 5G7

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

Bethammi Nursing Home
63 Carrie Street THUNDER BAY ON P7A 4J2

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

JULIE KUORIKOSKI (621), DEBBIE WARPULA (577), MELISSA HAMILTON (693)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 12 - 15, 2019.

The following Critical Incident System (CIS) intakes were inspected during this CIS Inspection:
- One intake related to personal support services, plan of care and prevention of abuse and neglect.

Additionally, Follow Up Inspection #2019_740621_0023 was conducted concurrently with this CIS Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the Registered Social Worker (RSW), a Registered Practical Nurse (RPN), Personal Support Worker's (PSWs), and a resident.

The Inspector also observed the provision of care and services to residents, reviewed the home's supporting documentation, including relevant health care records, and specific licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Reporting and Complaints

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur, shall immediately report the suspicion and the information upon which it was based to the Director: 2. Neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Ontario Regulation 79/10, s.5, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On dates in September 2018, January and February 2019, the home submitted written complaints to the Director, with regards to allegations of neglect for resident #001.

Inspector #621 reviewed the Long-Term Care Homes.net (ltchomes.net) reporting website and was unable to locate mandatory critical incident reports submitted by the home, for each of the neglect allegations made by the complainant.

The Inspector also reviewed the home's complaint records and identified another written complaint which the home had submitted on a day in August 2018, for which former DOC #115 documented in their internal complaints report and a letter to PSW #116 indicating, that PSW #116 had neglected resident #001 on a particular day in August 2018, and

failed to provide care as per the resident's plan of care over a certain time frame.

During a review of the home's adopted policy from Extendicare, titled "Zero Tolerance of Resident Abuse and Neglect Program, RC-02-01-01", last updated April 2017, neglect is identified as the failure to provide a resident with treatment, care, services, or assistance required for health, safety or well-being, and/or includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. Additionally, the policy identified that mandatory reporting under s.24(1) of the Ontario Long-Term Care Homes Act (LTCHA), requires a person to make an immediate report to the Director where there is reasonable suspicion that certain incidents resulted in harm or risk of harm.

During an interview with DOC #112, they reported that the home was required to submit, under the Mandatory Critical Incident System (MCIS), an immediate report to the Director, of any allegations, suspicions or witnessed incidents of neglect.

During an interview with the Administrator, they confirmed with Inspector #621 that for the founded incident of neglect identified in August 2018 by former DOC #115, as well as the three written allegations of neglect made by the complainant in September 2018, January 2019 and February 2019, an immediate report via the MCIS reporting system to the Director should have been made, and was not. [s. 24. (1)] (621)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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: 2. Neglect of a resident by the licensee or staff that results in harm or risk of harm to the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home had a compliance order from report #2019_768693_0005 for s.6(7) with a compliance date of July 22, 2019. The incidents identified within this report occurred prior to the compliance order due date.

On dates in September 2018, January 2019, and February 2019, the home submitted written complaints to the Director, with regards to allegations of staff to resident neglect towards resident #001.

a) Inspector #621 reviewed the home's complaints documentation and identified another written complaint which the home had submitted in August 2018, for which former DOC #115 documented in their internal complaints report and a letter to PSW #116 on the same date, indicating that PSW #116 had neglected resident #001 on a particular date in August 2018, and failed to provide care as per the resident's plan of care for a specified time period.

On review of the home's investigation notes for the incident from August 2018, an interview with PSW #116 reported that the PSW confirmed that they had not provided resident #001 with a specific care activity for a specified period of time.

On review of resident #001's care plan in effect at the time of the incident, it identified that resident #001 required a particular level of staff assistance with a certain care activity; and that staff were to assist with the identified care activity, over specified time intervals, up until a particular time of day.

During an interview with the Administrator, they reviewed the home's internal complaints investigation files and confirmed that for the August 2018, complaint, resident #001 had not been provided care as per their plan of care, with regards to a specific care activity.

b) Inspector #621 reviewed the home's complaints documentation for a written email complaint from September 2018 for resident #001, which alleged that on a date in August 2018, the PSW assigned to the resident had not completed a certain care activity with them, over a particular duration of time, and that the PSW acknowledged that the care had not been completed.

On review of the home's investigation notes for the incident in August 2018, the home's letter of response to the complainant in September 2018, confirmed that resident #001 did not have a care activity completed with them at a certain time, and that the PSW admitted to their error.

On review of resident #001's care plan in effect at the time of the incident, it identified that resident #001 required a particular level staff of assistance for a certain care activity; and that staff were to support the resident with this care activity at certain time intervals, up until a particular time of day.

During an interview with the Administrator, they reviewed the home's internal complaints investigation files and confirmed that for the August 2018, complaint, resident #001 had not been provided care as per their plan of care, with regards to a specific care activity.

c) Inspector #621 reviewed the home's complaints documentation for a written email complaint from January 2019, for resident #001, which alleged that on January 17, 2019, staff had been made aware by a visitor over a particular period of time, that resident #001 required assistance with a particular care activity, but that no one came to assist.

On review of the home's investigation notes for the incident in January 2019, the home's letter of response to the complainant confirmed that no PSW staff completed the identified care activity at a specified time; and that the RN on duty confirmed that they had received the same information from a visitor at a certain time, but left the home area without informing any staff member working at that time of resident #001's identified care needs.

On review of resident #001's care plan in effect at the time of the incident, it identified that resident #001 required staff assistance with a particular care activity, over specified intervals of time each day.

During an interview with the Administrator, they reviewed the home's internal complaint investigation files and confirmed that for the January 2019, complaint, resident #001 had

not been provided care as per their plan of care, with regards to a specific care activity. [s. 6. (7)] (621)

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home who received a written complaint concerning the care of a resident or the operation of the long-term care home, immediately forwarded it to the Director.

On a day in January 2019, the home submitted a written complaint to the Director, which alleged neglect of resident #001.

Inspector #621 reviewed the home's complaint records and identified another written complaint made on an earlier date in January 2019 for resident #001, regarding concerns with the staff's provision of care to the resident. The home's complaint record included details of an investigation that was completed, as well as an email response from former DOC #115.

Inspector #621 reviewed complaints received by the Centralized Intake Assessment and Triage Team (CIATT) email provided to homes for reporting written complaints, and found no email submission from the home for the additional written complaint, and the DOC's subsequent written response to the complainant on a particular date in January 2019.

During a review of the home's policy titled "Complaints Management Program, LTC 5-70", last reviewed December 2017, it identified that all written complaints received by the home were to be reported to the Ministry of Health and Long-Term Care, using the CIATT email address provided.

During an interview with DOC #112, they reported that the home was required to submit via email, all written complaints made to the home, and the homes letter of response, to the Director.

During an interview with the Administrator, they reviewed the home's complaint documentation with the Inspector concerning care issues raised by the complainant for resident #001 on the identified date in January 2019, as well as the home's email response to the complainant the next day. The Administrator confirmed that the email response forwarded to the complainant the next day, was the home's written response to the concerns raised; that an investigation into the care concerns was completed, and that a submission of both the complaint and the home's email response should have been forwarded to the Director, and were not. [s. 22. (1)] (621)

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included:

a) the nature of each verbal or written complaint; b) the date the complaint was received; c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken, and any follow-up action required; d) the final resolution, if any; e) every date on which any response was provided to the complainant and a description of the response; and f) any response made in turn by the complainant.

On dates in September 2018, January 2019, and February 2019, the home submitted written complaints to the Director, with regards to allegations of staff to resident neglect of resident #001.

Inspector #621 also reviewed the home's complaints records which identified a verbal complaint received by the home regarding resident #001's a specific number of care concerns identified from a particular date in August 2018.

The home's internal complaints form titled "Internal Complaint Documentation Form" was reviewed and found to be missing documentation under "Part 2: Management" pertaining

to the actions taken to resolve the complaint, correspondence provided to the complainant, and the complainant's response.

On review of the home's policy titled "Complaints Management Program, LTC 5-70", last approved in December 2017, it identified that the Manager and/or Director of Care was responsible to investigate all verbal complaints and provide a response to the complainant within the required time frame; with records maintained utilizing the "Internal Complaint Documentation Form(s)" part 1 and 2. Further, the policy identified that a documented record was kept in the home that included: the nature of each verbal or written complaint; the date of the complaint was received; the type of action taken to resolve the complaint; including the date of the action; time frames for actions to be taken and any follow up required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

During an interview with the Administrator, they reported to the Inspector that it was their expectation that all parts of the home's "Internal Complaint Documentation Form" for all verbal and written complaints were completed in full, consistent with the home's policy and legislative requirements. The Administrator confirmed that part 2 of the home's internal complaint form for the August 2018, verbal complaint was incomplete, with regards to the actions taken to resolve the complaint, correspondence provided to the complainant, and the complainant's response. [s. 101. (2)] (621)

Issued on this 22nd day of August, 2019

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

Original report signed by the inspector.