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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 25, 2016;	2015_435621_0012 (A1)	029995-15	Follow up

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET THUNDER BAY ON P7C 4Y7

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

JULIE KUORIKOSKI (621) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date was changed for s.20 with a revised compliance date of March 31, 2016.

Issued on this 25 day of February 2016 (A1)

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

Original report signed by the inspector.

Ontario

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

JULIE KUORIKOSKI (621) - (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): December 14, 15, 16, 17, and 18, 2015

This inspection was conducted concurrently with Critical Incident Inspection 2015_4356621_0011 and Complaint Inspection 2015_435621_0010. Non compliance from Critical Incident Inspection 2015_4356621_0011, with exception of s.221.(1), has been addressed in this Follow Up Inspection.

This inspection was conducted to follow up compliance order #001, Long Term Care Homes Act (LTCHA) s.19.(1); compliance order #002, LTCHA s.24(1); compliance order #003, LTCHA s.6(1) and compliance order #004, LTCHA s.6(10).

During the course of the inspection, the inspector(s) spoke with the VP Senior Health Services, Director, Clinical Manager(s), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family Members and Residents.

Observations were made of resident care areas, provision of care and services to residents as well as staff to resident and resident interactions. The home's health care records for several residents were reviewed, along with relevant policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #001	2015_333577_0012	621

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' plans of care set out clear directions to staff and others who provided direct care.

During previous inspection #2015_333577_0012, a compliance order was issued for s.6(1)(c) identifying that resident #009's plan of care did not set out clear directions with respect to the use of bed rails.

A review of this resident's care plan specifically relating to bed rail use, revealed that under the Aids to Daily Living focus, staff will ensure two bed rails are up when in bed. However, the Falls/Balance and Bed Mobility foci identified that four bed rails are to be up when resident is in bed. Consequently, this care plan described two different interventions related to the use of bed rails.

An interview with PSW #128 regarding resident #009's use of bed rails revealed that this resident required all four bed rails up when in bed.

In an interview with Manager #105 regarding the update of resident care plans, Inspector #543 notified them that this resident's care plan did not provide clear direction specifically relating to bed rails, where in one section it stated that the resident required two bed rails up when in bed, and another identified that the resident required four bed rails up when in bed. They agreed that the plan of care did not

provide clear direction regarding the use of bed rails. [s. 6. (1) (c)]

2. The licensee has failed to ensure that residents' plans of care set out clear directions to staff and others who provided direct care.

During previous inspection #2015_333577_0012, a compliance order was issued for s.6(1)(c) which identified that resident #006's plan of care did not set out clear direction with respect to this resident wandering in and out of other residents' rooms.

A review of this resident's most recent care plan revealed that under the Behavior Problems section, this resident's care plan did not address that the resident will wander in and out of other residents' rooms. The wandering section of the care plan identified that staff will take the resident to their room after meals to re-orientate to their room due to on-going confusion.

An interview with PSW #115 regarding this resident's behaviours identified that resident #006 still wandered in and out of other residents' rooms.

During an interview with the Manager #105 concerning the update of resident care plans, Inspector #543 notified them that resident #006's care plan did not provide clear direction specifically relating to wandering behaviours, and did not identify that this resident would wander in and out of other residents' rooms. They agreed that the plan of care did not provide clear direction regarding the resident's wandering behaviour. [s. 6. (1) (c)]

3. The licensee failed to ensure that residents were reassessed and the plans of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan of care was no longer necessary.

On December 15th and 16th, 2015, Inspector #612 found resident #014 seated in a wheelchair. During interviews with PSW #125, #129, #130, and RN #131, all reported to Inspector #621 that the resident was now in an assistive device and was no longer wandering the unit. They also reported that the resident previously wore a wander guard, but that it was no longer required by the resident and it had been removed.

Inspector #621 reviewed the care plan for resident #014 with RN #131 who verified there was no mention in the most recent care plan that the resident required an assistive device for ambulation. They also verified that the care plan reported twice

under "Locomotion On and Locomotion Off Unit" sections that a wander guard had been discontinued on a certain month in 2012, then identified a wander guard in place in a specific month in 2015, under the "Restraints" section, but did not report on the discontinuation of a wander guard later in 2015.

During an interview with Manager #105 they identified that it is the home's expectation that when care needs change, the registered staff would document these changes in the electronic record and update the care plan. They confirmed that the care plan did not reflect this resident's current care needs relating to their assistive device and wander guard use. [s. 6. (10) (b)]

4. The licensee failed to ensure that residents were reassessed and the plans of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan of care was no longer necessary.

Inspector #621 observed on December 15th and 16th, 2015, resident #001 was seated in a wheelchair.

During an interview with RN #114 on December 15, 2015, the current care plan for resident #001 from Mede-care was reviewed. RN #114 confirmed that the resident was in a wheelchair and no longer walked on their own. They also confirmed that care plan strategies, which identified that staff were to ensure resident #001 wears proper footwear at all times while ambulating, did not reflect the resident's current care needs. Similarly, the Falls/Balance section of the care plan identified that staff were to encourage this resident to wear non-slip socks and shoes at all times while walking. Again, RN # 114 confirmed that the resident no longer walked and that this would need to be removed from the care plan.

During an interview with Manager #121 on December 16, 2015, they confirmed that expectations for documentation of changes to resident care needs would include information being updated in the electronic progress notes, resident care plan, white boards on the units and the staff log book as examples. Manager #121 reviewed the care plan with Inspector #621 for resident #001 and acknowledged the plan of care had not been updated when the resident's care needs changed. They also reported to the inspector that care plan documentation was an area requiring improvement for the home. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 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 failed to ensure that a person who had reasonable grounds to suspect that abuse of 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 immediately reported the suspicion and the information upon which it was based to the Director.

A Critical incident (CI) report that was received by the Director in December 2014, reported an incident of resident to resident abuse. The incident occurred in November 2014, however, it was not reported to the Director until 45 days later.

During an interview with Manager #105 on December 15, 2015, it was confirmed to Inspector #621 that the CI was not reported immediately to the Director as per legislative requirements. [s. 24. (1)]

2. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of 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 immediately reported the suspicion and the information upon which it was based to the Director.

A Critical incident (CI) report received by the Director in November 2014, identified an incident of resident to resident abuse. Although RN #104 notified Manager #112 of the incident in November 2014, it was not reported to the Director until 62 days later.

During an interview with Manager #105 on December 15, 2015, it was confirmed to Inspector #621 that the CI was not reported immediately to the Director as per legislative requirements. [s. 24. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A critical incident (CI) report received in June 2015, (after hours pager) by the Director reported that PSW #120 was allegedly verbally abusive and neglectful towards resident #013.

A review of the home's internal investigation revealed, in a documented interview with the Manager #105 and PSW #120, that PSW #125 witnessed the incident and stated that they were providing care to another resident when PSW #120 was overheard being verbally abusive towards resident #013.

A documented interview with Manager #105 and PSW #120 further revealed that PSW #120 verbally abused the resident and then left the resident who was soiled for hours while they completed the rest of their resident care on the unit, completed dining room service, and had their staff break. In the report, PSW #120 confirmed that they verbally abused the resident. When questioned about leaving a resident in an unhealthy condition, PSW #120 was reported to have also said that other staff could have gone in, but instead that they went on with their care for other residents.

A review of the Home's policy LTC 5-50 entitled Zero Tolerance of Abuse and Neglect of Residents reported that they are committed to zero tolerance of abuse and neglect; that all employees must protect the rights of each and every resident entrusted to their care and that residents living in the Home have "the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse."

Documentation from the home's internal investigation determined that PSW #120's actions constituted verbal abuse and neglect of resident #013 and evidenced that the home was not in compliance with their written policy on zero tolerance of abuse and neglect of residents. [s. 20. (1)]

2. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A critical incident report (CI) received in November 2015, reported PSW #126 was allegedly physically abusive towards resident #011 in October 2015.

Review of the home's internal investigation revealed that in October 2015, PSW #126 pulled resident #011's hair while providing care, causing the resident to jerk their head and body upward. PSW #127 stated in the investigation that they were assisting PSW #126 with resident care, and after turning to grab supplies from a cart they turned back around and witnessed PSW #126 pulling the resident's hair. The witness stated that the resident's head jerked up and they gasped.

A review of the Home's policy LTC 5-50 entitled Zero Tolerance of Abuse and Neglect of Residents reported that they are committed to zero tolerance of abuse and neglect; that all employees must protect the rights of each and every resident entrusted to their care and that residents living in the Home have "the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse."

Result of the home's internal investigation revealed that evidence supported allegations of abuse, and a letter addressed to PSW #126 indicated that the investigation determined that their actions constituted physical abuse. Consequently, the home was not in compliance with their written policy on zero tolerance of abuse and neglect of residents. [s. 20. (1)]

3. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A critical incident (CI) received in January 2015, identified that resident #001 was allegedly physically abusive towards resident #002, which resulted in injury.

Review of the home's internal investigation revealed that in January 2015, resident #001 pushed resident #002 in their wheelchair into another resident's room. When PSW#101 and PSW #102 attempted to redirect both residents, resident #001 was reported to have become physically aggressive and punched resident #002. This resulted in resident #002 in sustaining an injury.

A review of a previous critical incident report received by the Director in December 2014, identified resident #001 was also involved in an act of physical aggression towards resident #003, which resulted in injury.

A review of the Home's policy LTC 5-50 entitled Zero Tolerance of Abuse and Neglect of Residents reported that they are committed to zero tolerance of abuse and neglect; that all employees must protect the rights of each and every resident entrusted to their care and that residents living in the Home have "the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse."

Result of the home's internal investigations for both incidents revealed that evidence supported allegations of resident to resident physical abuse. Consequently, the home was not in compliance with their written policy on zero tolerance of abuse and neglect of residents. [s. 20. (1)]

4. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A critical incident (CI) received in September 2015, indicated PSW #109 was allegedly

verbally abusive towards resident #005 in September 2015.

Review of the home's internal investigation revealed that in September 2015, resident #005 was exhibiting responsive behaviours during care. PSW #109 was said to have lashed out verbally using profanity and inappropriate language towards this resident. PSW #110 was identified to have witnessed the incident and reported it to RN #111 on duty.

It was previously reported through a critical incident received by the Director in August 2015, that PSW #109 had also been verbally abusive and used profane body language towards resident #006 during care which was witnessed by a student who was assisting with care.

A review of the Home's policy LTC 5-50 entitled Zero Tolerance of Abuse and Neglect of Residents reported that they are committed to zero tolerance of abuse and neglect; that all employees must protect the rights of each and every resident entrusted to their care and that residents living in the Home have "the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse."

On review of the home's internal investigation following both incidents, it was determined that the actions of PSW #109 constituted verbal abuse. Consequently, the home was not in compliance with their written policy on zero tolerance of abuse and neglect of residents. [s. 20. (1)]

5. The licensee has failed to ensure that at minimum, the written policy to promote zero tolerance of abuse and neglect of residents clearly sets out what constitutes abuse and neglect.

A review of the home's policy LTC 5-50 entitled Zero Tolerance of Abuse and Neglect of Residents referenced a verbal abuse definition from the Health Care Health and Safety Association in 2005 which did not match the definition as outlined Long Term Care Homes Act (LTCHA), 2007, O. Reg. 79/10, s.2(1)(a)(b). The home's policy however identified on page one under "Definitions" that the policy used the definition of abuse and neglect from the Long Term Care Homes Act, 2007 (LTCHA). Consequently, the home was not in compliance with a written policy to promote zero tolerance of abuse and neglect of residents that clearly set out what constitutes abuse and neglect. [s. 20. (2) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 004

Issued on this 25 day of February 2016 (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

Health System Accountability and Performance Division
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : JULIE KUORIKOSKI (621) - (A1)

Inspection No. / No de l'inspection : 2015_435621_0012 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 029995-15 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Feb 25, 2016;(A1)

Licensee / Titulaire de permis :

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LTC Home / Foyer de SLD :

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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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Meaghan Sharp

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To ST. JOSEPH'S CARE GROUP, 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: 2015_333577_0012, CO #003; 2015_333577_0012, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall:

a) review and revise the plans of care for resident #009 and #006, to ensure that they set out clear directions to enable staff and others who provide direct care to appropriately care for each resident;

b) develop a process to ensure that the plans of care are clearly communicated to and understood by all staff and others who provide direct care to the residents;

c) develop an auditing process for written plans of care that will identify problems, gaps so that corrections can be made in order to provide clear directions to staff and others who provide direct care to residents; and

d) educate and retrain staff involved in developing residents' written plans of care, including the risks associated with not providing clear directions to staff and others who provide direct care to residents.

Grounds / Motifs :

1. The licensee has failed to ensure that residents' plans of care set out clear directions to staff and others who provided direct care.

During previous inspection #2015_333577_0012, a compliance order was issued for s.6(1)(c) identifying that resident #009's plan of care did not set out clear directions with respect to the use of bed rails.

A review of this resident's care plan specifically relating to bed rail use, revealed that under the Aids to Daily Living focus, staff will ensure two bed rails are up when in bed. However, the Falls/Balance and Bed Mobility foci identified that four bed rails are to be up when resident is in bed. Consequently, this care plan described two different interventions related to the use of bed rails.

An interview with PSW #128 regarding resident #009's use of bed rails revealed that this resident required all four bed rails up when in bed.

In an interview with Manager #105 regarding the update of resident care plans, Inspector #543 notified them that this resident's care plan did not provide clear direction specifically relating to bed rails, where in one section it stated that the resident required two bed rails up when in bed, and another identified that the resident required four bed rails up when in bed. They agreed that the plan of care did not provide clear direction regarding the use of bed rails. (543)

2. The licensee has failed to ensure that residents' plans of care set out clear directions to staff and others who provided direct care.

During previous inspection #2015_333577_0012, a compliance order was issued for s.6(1)(c) which identified that resident #006's plan of care did not set out clear direction with respect to this resident wandering in and out of other residents' rooms.

A review of this resident's most recent care plan revealed that under the Behavior Problems section, this resident's care plan did not address that the resident will wander in and out of other residents' rooms. The wandering section of the care plan identified that staff will take the resident to their room after meals to re-orientate to their room due to on-going confusion.

An interview with PSW #115 regarding this resident's behaviours identified that resident #006 still wandered in and out of other residents' rooms.

During an interview with the Manager #105 concerning the update of resident care plans, Inspector #543 notified them that resident #006's care plan did not provide clear direction specifically relating to wandering behaviours, and did not identify that this resident would wander in and out of other residents' rooms. They agreed that the plan of care did not provide clear direction regarding the resident's wandering behaviour.

Non-compliance pursuant to LTCHA, 2007 S.O. 2007, s.6 (1) has been previously identified under inspection report 2014_0246196_0016 with a voluntary plan of correction, and in inspection 2015_333577_0012 (A1) including a compliance order served October 29, 2015.

The decision to re-issue this compliance order was based on the scope of this issue which was a pattern of residents' plans of care not providing clear direction to staff providing care; the severity which indicated a potential for actual harm, and the compliance history which in spite of a previous compliance order has continued with this area of the legislation. (543)

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

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

Feb 26, 2016

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2015_333577_0012, 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 all staff and others who provide care to residents immediately reports the suspicion and the information of any alleged or actual abuse to the Director.

Grounds / Motifs :

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

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of 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 immediately reported the suspicion and the information upon which it was based to the Director.

A Critical incident (CI) report was received by the Director in December 2014, reported an incident of resident to resident abuse. The incident occurred in November 2014, however, it was not reported to the Director until 45 days later.

During an interview with Manager #105 on December 15, 2015, it was confirmed to Inspector #621 that the CI was not reported immediately to the Director as per legislative requirements. [(621)

2. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of 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 immediately reported the suspicion and the information upon which it was based to the Director.

A Critical incident (CI) report received by the Director in November 2014, identified an incident of resident to resident abuse. Although RN #104 notified Manager #112 of the incident in November 2014, it was not reported to the Director until 62 days later.

During an interview with Manager #105 on December 15, 2015, it was confirmed to Inspector #621 that the CI was not reported immediately to the Director as per legislative requirements.

Non-compliance pursuant to LTCHA, 2007 S.O. 2007, s.24(1) has been previously identified under inspection report 2015_333577_0012 (A1) including a compliance order served October 29, 2015.

The decision to re-issue this compliance order was based on the scope of this issue, which involved a pattern of late reporting to the Director; the severity which indicated a potential for actual harm; and the compliance history, which despite previous non-compliance has continued in this area of the legislation. (621)

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

Feb 26, 2016

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

1) The licensee shall ensure that residents #014 and #001 are reassessed and their written plans of care are reviewed and revised to reflect changes identified in the reassessments.

2) The licensee shall develop and implement a system to ensure that all residents are reassessed and the plans of care are reviewed and revised at least every six months and whenever their care needs change or care set out in the plan of care is no longer necessary.

Grounds / Motifs :

1. The licensee failed to ensure that residents were reassessed and the plans of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan of care was no longer necessary.

On December 15th and 16th, 2015, Inspector #612 found resident #014 seated in a wheelchair. During interviews with PSW #125, #129, #130, and RN #131, all reported to Inspector #621 that the resident was now using an assistive device and was no longer wandering the unit. They also reported that the resident previously wore a wander guard, but that it was no longer required by the resident and it had been removed.

Inspector #621 reviewed the care plan for resident #014 with RN #131 who verified there was no mention in the most recent care plan that the resident required an assistive device for ambulation. They also verified that the care plan reported twice under "Locomotion On and Locomotion Off Unit" sections that a wander guard had been discontinued on a certain month in 2012, then identified a wander guard in place in a specific month in 2015, under the "Restraints" section, but did not report on the discontinuation of a wander guard later in 2015.

During an interview with Manager #105 they identified that it is the home's expectation that when care needs change, the registered staff would document these changes in the electronic record and update the care plan. They confirmed that the care plan did not reflect this resident's current care needs relating to their assistive device and wander guard use. (621)

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

Inspector #621 observed on December 15th and 16th, 2015, resident #001 was seated in a wheelchair.

During an interview with RN #114 on December 15, 2015, the current care plan for

resident #001 from Mede-care was reviewed. RN #114 confirmed that the resident was in a wheelchair and no longer walked on their own. They also confirmed that care plan strategies, which identified that staff were to ensure resident #001 wears proper footwear at all times while ambulating, did not reflect the resident's current care needs. Similarly, the Falls/Balance section of the care plan identified that staff were to encourage this resident to wear non-slip socks and shoes at all times while walking. Again, RN # 114 confirmed that the resident no longer walked and that this would need to be removed from the care plan.

During an interview with Manager #121 on December 16, 2015, they confirmed that expectations for documentation of changes to resident care needs would include information being updated in the electronic progress notes, resident care plan, white boards on the units and the staff log book as examples. Manager #121 reviewed the care plan with Inspector #621 for resident #001 and acknowledged the plan of care had not been updated when the resident's care needs changed. They also reported to the Inspector that care plan documentation was an area requiring improvement for the home.

Non-compliance pursuant to LTCHA, 2007 S.O. 2007, s.6 (10) have been previously identified under inspection report 2013_104196_0001 for a written notification; and 2015_333577_0012 (A1) involving a compliance order served October 29, 2015.

The decision to re-issue this compliance order was based on the scope of this issue was a pattern of residents written plans of care not being reviewed and revised whenever their care needs changed or care set out in the plan was no longer necessary; the severity which indicated a potential for actual harm, and the compliance history which in spite of a previous compliance order has continued with this area of the legislation. (621)

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

Feb 26, 2016

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

Order / Ordre :

(A1)
The licensee shall ensure that:

a) The home s policy LTC 5-50 last updated January 2015 is revised to include the definition of verbal abuse from the Long Term Care Homes Act (LTCHA), 2007, O.Reg 79 10, s.2(1) (a)(b).

b) All staff receive training on the home s revised policy entitled "Zero Tolerance of Abuse and Neglect of Residents" and that the policy is complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A critical incident (CI) received in September 2015, indicated PSW #109 was allegedly verbally abusive towards resident #005 in September 2015.

Review of the home's internal investigation revealed that in September 2015, resident #005 was exhibiting responsive behaviours during care. PSW #109 was said to have lashed out verbally using profanity and inappropriate language towards this resident. PSW #110 was identified to have witnessed the incident and reported it to RN #111 on duty.

It was previously reported through a critical incident received by the Director in August 2015, that PSW #109 had also been verbally abusive and used profane body language towards resident #006 during care which was witnessed by a student who was assisting with care.

A review of the Home's policy LTC 5-50 entitled Zero Tolerance of Abuse and Neglect of Residents reported that they are committed to zero tolerance of abuse and neglect; that all employees must protect the rights of each and every resident entrusted to their care and that residents living in the Home have "the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse."

On review of the home's internal investigation following both incidents, it was determined that the actions of PSW #109 constituted verbal abuse. Consequently, the home was not in compliance with their written policy on zero tolerance of abuse and neglect of residents. (621)

2. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A critical incident (CI) received in January 2015, identified that resident #001 was allegedly physically abusive towards resident #002, which resulted in injury.

Review of the home's internal investigation revealed that in January 2015, resident #001 pushed resident #002 in their wheelchair into another resident's room. When PSW#101 and PSW #102 attempted to redirect both residents, resident #001 was reported to have become physically aggressive and punched resident #002. This resulted in resident #002 in sustaining an injury.

A review of a previous critical incident report received by the Director in December 2014, identified resident #001 was also involved in an act of physical aggression towards resident #003, which resulted in injury.

A review of the Home's policy LTC 5-50 entitled Zero Tolerance of Abuse and Neglect of Residents reported that they are committed to zero tolerance of abuse and neglect; that all employees must protect the rights of each and every resident entrusted to their care and that residents living in the Home have "the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse."

Result of the home's internal investigations for both incidents revealed that evidence supported allegations of resident to resident physical abuse. Consequently, the home was not in compliance with their written policy on zero tolerance of abuse and neglect of residents. (621)

3. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A critical incident report (CI) received in November 2015, reported PSW #126 was allegedly physically abusive towards resident #011 in October 2015.

Review of the home's internal investigation revealed that in October 2015, PSW #126 pulled resident #011's hair while providing care, causing the resident to jerk their head and body upward. PSW #127 stated in the investigation that they were assisting PSW #126 with resident care, and after turning to grab supplies from a cart they turned back around and witnessed PSW #126 pulling the resident's hair. The witness stated that the resident's head jerked up and they gasped.

A review of the Home's policy LTC 5-50 entitled Zero Tolerance of Abuse and Neglect of Residents reported that they are committed to zero tolerance of abuse and neglect; that all employees must protect the rights of each and every resident entrusted to their care and that residents living in the Home have "the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse."

Result of the home's internal investigation revealed that evidence supported allegations of abuse, and a letter addressed to PSW #126 indicated that the investigation determined that their actions constituted physical abuse. Consequently, the home was not in compliance with their written policy on zero tolerance of abuse and neglect of residents. (621)

4. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A critical incident (CI) report received in June 2015, (after hours pager) by the Director reported that PSW #120 was allegedly verbally abusive and neglectful towards resident #013.

A review of the home's internal investigation revealed, in a documented interview with the Manager #105 and PSW #120, that PSW #125 witnessed the incident and

stated that they were providing care to another resident when PSW #120 was overheard being verbally abusive towards resident #013.

A documented interview with Manager #105 and PSW #120 further revealed that PSW #120 verbally abused the resident and then left the resident who was soiled for hours while they completed the rest of their resident care on the unit, completed dining room service, and had their staff break. In the report, PSW #120 confirmed that they verbally abused the resident. When questioned about leaving a resident in an unhealthy condition, PSW #120 was reported to have also said that other staff could have gone in, but instead that they went on with their care for other residents.

A review of the Home's policy LTC 5-50 entitled Zero Tolerance of Abuse and Neglect of Residents reported that they are committed to zero tolerance of abuse and neglect; that all employees must protect the rights of each and every resident entrusted to their care and that residents living in the Home have "the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse."

Documentation from the home's internal investigation determined that PSW #120's actions constituted verbal abuse and neglect of resident #013 and evidenced that the home was not in compliance with their written policy on zero tolerance of abuse and neglect of residents.

Non-compliance pursuant to LTCHA, 2007 S.O. 2007, s.24(1) has been previously identified under inspection report 2015_333577_0012 (A1) including a compliance order served October 29, 2015.

The decision to issue this compliance order was based on the scope of this issue which was identified as a pattern of home's non-compliance with its policy promoting zero tolerance of abuse and neglect; the severity which indicated actual harm to residents was identified; and ongoing non-compliance with legislation concerning prevention of abuse and neglect. (621)

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

Mar 31, 2016(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

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

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
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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l’amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 25 day of February 2016 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : JULIE KUORIKOSKI - (A1)

Service Area Office /
Bureau régional de services : Sudbury