Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Inspections Branch

Ministère de la Santé et des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**
Name of Director:	Karen Simpson
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 □ Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 X Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Logs # of original inspection (if applicable):	
Original Inspection #:	
Licensee:	St. Joseph's Care Group
LTC Home:	Hogarth Riverview Manor
Name of Administrator:	Soili Helppi

Background:
The licensee of Hogarth Riverview Manor ("the home") is currently in non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) and Ontario Regulation 79/10 ("the Regulation"). Since January 2016, when the home expanded and was licensed for additional beds, the licensee has repeatedly failed to comply with several requirements, including but not limited to, ongoing non-compliance with resident care requirements; protecting residents from abuse; not following plans of care; and not meeting reporting obligations to the Director. Also since 2015, the licensee has had ongoing leadership turnover in key leadership positions. There has been a lack of consistent senior leadership (Vice President of Seniors' Health, St. Joseph's Care Group; Administrator; Director of Care) to support clinical managers, many of whom have limited long-term care experience. This leadership turnover has contributed to the licensee's inability to attain and sustain compliance with requirements under the LTCHA. Hogarth Riverview Manor ("the home") is a long-term care home in Thunder Bay previously licensed for 96 beds in the home. In January 2016, the home developed a new 320 bed wing (150 beds from the closed Dawson Court, 150 beds from the closed Grandview Lodge and 20 new beds funded by the North West

Local Health Integration Network (LHIN)) to the existing 96 bed location, resulting in a new license of 416 beds in the home.

In May 2017, approval was given by the Director of Licensing and Policy Branch (LPB) to admit residents into the home as part of the CEISS phase 2 expansion. As a result, Hogarth Riverview Manor is currently licensed for 543.

Subsection 156(1) of the LTCHA states that the Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the long-term care home.

Subsection 156(2) of the LTCHA states that an order may be made under this section if (a) the licensee has not complied with a requirement under the LTCHA; and (b) there are reasonable grounds to believe that the licensee cannot or will not properly manage the long-term care home or cannot do so without assistance. A requirement under the LTCHA is defined in section 2 of the LTCHA as a requirement contained in the LTCHA, in the regulations or in an order or agreement made under the LTCHA, and includes a condition of licence issued under the LTCHA.

The Director is issuing this Mandatory Management Order because of the licensee's ongoing and repeated failure to comply with several requirements under the LTCHA and the Regulation, and the Director has reasonable grounds to believe that the licensee cannot properly manage the long-term care home. This belief is based on the licensee's ongoing and persistent non-compliance with requirements under the LTCHA and the Regulation, as outlined in the grounds, including a history of issuing and re-issuing multiple Compliance Orders, the licensee's failure to comply with Compliance Orders, a direction to the placement coordinator to cease admissions on November 9, 2016, and the ongoing changes with the management of the home that have not ensured the home has stable leadership in place with the necessary training, knowledge and expertise to ensure Compliance Orders are complied with and to provide direction to staff to ensure resident care is provided in accordance with the LTCHA and Regulation.

Order:	

To St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to: *Long-Term Care Homes Act, 2007,* S. O. 2007, c, s. 156(1). The Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the long-term care home.

Order: St. Joseph's Care Group ('the licensee") is ordered:

(a) To retain a person described in paragraph (c) or (d), where applicable, of this Order to manage Hogarth Riverview Manor located at 300 Lillie Street, Thunder Bay, Ontario ("the long-term care home");

(b) To submit to the Director, LTC Inspections Branch (LTCIB) within **7 calendar days** of being served with this Order a proposed person described in paragraph (a) to this Order;

(c) the person described in paragraph (a) to this Order must be acceptable to the Director and approved by the Director, LTCIB in writing;

(d) if the licensee does not submit a proposed person described in paragraph (a) to this Order to the Director, LTCIB within the time period specified in paragraph (b) to this Order, the Director, LTCIB may select a person that the licensee must retain to manage the long-term care home

(e) the person described in paragraph (a) to this Order, must be acceptable to the Director, and must have specific qualifications, including:

(i) the experience, skills and expertise required to operate and manage a long-term care (LTC) home in Ontario and to maintain compliance with the *Long-Term Care Homes Act,* 2007 and O. Reg. 79/10;

(ii) have a Good Compliance Record, which for the purpose of this Order means the LTC home for which the person described in paragraph (a) to this Order is a licensee or manager, or to which the person described in paragraph (a) to this Order provides management services and that has a compliance record under the LTCHA that is considered to be substantially compliant including:

1. critical incidents that occur are reported as required;

2. complaints are managed effectively in the LTC home;

3. the LTC home develops policies/procedures using evidence-based practices and quality strategies;

4. the LTC home responds to compliance issues identified during Ministry inspections; and

5. non-compliance in areas of actual harm or high risk of harm to residents and any other person identified during inspections are rectified within the time frame required by the Ministry.

(iii) demonstrate that they have not, under the laws of any province, territory, state or country, in the three years prior to this order,

1. been declared bankrupt or made a voluntary assignment in bankruptcy;

2. made a proposal under any legislation relating to bankruptcy or insolvency; or

3. have been subject to or instituted any proceedings, arrangement, or compromise with creditors including having had a receiver and/or manager appointed to hold his, her, or its assets.

(f) to submit to the Director, LTC Licensing and Policy Branch (LPB) a written contract pursuant to section 110 of the LTCHA **within 7 calendar days** of receiving approval of the Director, LTCIB pursuant to paragraph (c) of this Order or where the Director exercises discretion and selects a person pursuant to paragraph (d) of this Order;

(g) to execute the written contract **within 24 hours** of receiving approval of the written contract from the Director, LPB pursuant to section 110 of the *Long-Term Care Homes Act,* 2007 and to deliver a copy of that contract once executed to the Director, LPB;

(h) to submit to the Director, LTCIB a management plan, prepared in collaboration with the person described in paragraph (a) to this Order, to manage the long-term care home and that specifically addresses strategies to achieve compliance with those areas identified in the Grounds to this Order as being in non-compliance **within 30 calendar days** of receiving approval of the Director, LTCIB pursuant to paragraph (c) of this Order or where the Director exercises discretion and selects a person pursuant to paragraph (d) of this Order;

(i) the person approved by the Director, LTCIB pursuant to paragraph (c) to this Order or the person selected by the Director, LTCIB where the Director exercises discretion pursuant to paragraph (d) of this Order shall begin managing the home in accordance with the written contract described in paragraph (g) to this Order **within 24 hours** of the execution of that written contract;

(j) the management of the home by the person described in paragraph (a) to this Order is effective until advised otherwise by the Director, LTCIB; and

(k) any and all costs associated with complying with this Order are to be paid for by the licensee, including for certainty, but not limited to, all costs associated with retaining the person described in paragraph (a) to this Order.

Grounds:
St. Joseph's Care Group ("the licensee") is licensed to operate the long-term care home known as Hogarth Riverview Manor located at 300 Lillie Street, Thunder Bay, Ontario ("Hogarth Riverview Manor" or "the home").

Serious and ongoing non-compliance with requirements under the LTCHA and Orders, as referred to in detail below, have been identified and continue to occur at Hogarth Riverview Manor. The seriousness of the licensee's failure to comply with requirements under the LTCHA. The Director, LTCIB is issuing a Mandatory Management Order as the Director has reasonable grounds to believe that the licensee cannot properly manage the home. The licensee's ability to comply with requirements under the LTCHA has not improved and is significantly affecting the quality of care and quality of life of residents in the home for the following reasons:

Management Instability:

- There have been numerous changes in the home's leadership since 2015, which has impacted the licensee's ability to properly manage the home and placed the stability of the overall operations of the home at risk:
    - From 2014 to 2016, one individual held the responsibilities of the Vice President Seniors' Health, St. Joseph's Care Group and Administrator of Hogarth Riverview Manor concurrently. In addition to the former responsibilities, for over a two week period in 2016 they also assumed the role of Director of Care. As Vice President they were responsible for two homes (Hogarth Riverview Manor and Bethammi Nursing Home), Sister Leila Greco Apartments, P.R. Cook Apartments and the Regional Behavioural Support Unit. As Administrator they were responsible for the 416 beds at Hogarth Riverview Manor.
    - For a three month period in 2017, one individual held the responsibilities of the Vice President Seniors' Health, St. Joseph's Care Group and Administrator of Hogarth Riverview Manor concurrently. This individual did not complete the required training required by s. 76(1) of the LTCHA on the home's policy to promote zero tolerance of abuse and neglect of residents including but not limited to understanding the requirements related to reporting critical incidents to the Director prior to assuming their responsibilities as Administrator. This individual had no long-term care home experience prior to assuming the Administrator role.
    - In addition to the above, in 2017 in the role of Vice President Seniors' Health, another individual did not report certain matters to the Director in accordance with the LTCHA and regulations despite having acted in the Administrator role for the previous six months.
    - Since 2016, the Vice President Seniors' Health, St. Joseph's Care Group has been held by three different people.

- The licensee restructured the management team at the home in 2016 to ensure that there was a Director of Care and an Administrator who met the qualifications set out in the Regulation and that they were working onsite for the required hours per week.
    - Since 2016, the licensee has had five different individuals fill the Administrator position, either in the capacity of an interim/Acting Administrator or permanent Administrator.

- Since 2016, the licensee has had five different individuals fill the Director of Care position, either in the capacity of an interim/Acting Director of Care or permanent Director of Care.

- During Complaint Inspection # 2017_509617_0018, Critical Incident Inspection #2017_509617_0017 and Follow-Up Inspection # 2017_509617_0019, the Director of Care presented themselves to the Inspectors as the Director of Care and Acting Administrator. The licensee subsequently stated three days later that the Vice President Seniors' Health was the Acting Administrator and had been for two weeks prior to the inspection. The fact that this was not understood or known by the Director of Care demonstrates a lack of communication by the licensee in ensuring that the leadership in the home were aware of their responsibilities in the home and understood who was in charge of the long-term care home and responsible for its management in accordance with the LTCHA, s. 70(2).

- The home is licensed for 543 beds and Clinical Managers are assigned to manage specific home areas in the facility to oversee the care on the unit. Of the five Clinical Managers, only two were in their current positions prior to 2017 and only two of the five have previous long-term care home experience.

- Since 2016, the licensee has had four different individuals fill the position of Clinical Manager for Floors 4 & 5.

- Since 2016, the licensee has had three different individuals fill the position of Clinical Manager for Floors 2 & 3.

- In 2017, the licensee has had two different individuals fill the position of Clinical Manager for the Groves, Birch and Spruce units.

Cease of Admissions

In January 2016, the home began their expansion from 96 beds to 543 beds. In the same month, the Ministry received multiple complaints from staff and community members concerning resident care and safety at the home. Twelve inspections were conducted between January and October 2016. The compliance issues identified in these inspections led the Director on November 7, 2016, to direct a cease of admissions pursuant to subsection 50(1) of the LTCHA, as the Director was of the belief that there was a risk of harm to the health or well-being of residents or persons who might be admitted as residents to the home.

The most concerning areas of non-compliance that were identified in inspections and formed the basis for the Director's decision to cease admissions were:

- failing to protect residents from abuse;
- staff failing to provide and document the care set out in resident plans of care;
- failing to ensure all staff were re-trained on the licensee's zero tolerance of abuse policy;
- failing to have a staffing plan to address the needs of all residents and that the plan was implemented;
- failing to ensuring there was a Director of Care who met the qualifications onsite as required; and
- failing to ensure there was an Administrator who met the qualifications onsite as required.

The cease of admissions was lifted on January 18, 2017.

Other Enforcement Actions

Since January 1, 2014, 24 inspections have been conducted at the home, 18 of which have taken place since the expansion of the home in January 2016.

1) September 2, 2014, Resident Quality Inspection # 2014_246196_0016, served February 25, 2015, non-compliance was identified resulting in 16 written notifications, including seven voluntary plans of correction.

2) June 15, 2015, Resident Quality Inspection # 2015_333577_0012 (A1), served October 09, 2015, and amended on October 29, 2015, non-compliance was identified resulting in 16 written notifications, including 7 voluntary plans of correction, and 4 compliance orders.

3) December 12, 2015, Critical Incident Inspection # 2015_435621_0011, served January 26, 2016, non-compliance was identified resulting in one written notification, including one voluntary plan of correction.

4) December 12, 2015, Follow Up Inspection # 2015_435621_0012 (A1), served February 16, 2016, and amended on February 25, 2016, non-compliance was identified resulting in three written notifications, including four compliance orders.

5) December 12, 2015, Complaint Inspection # 2015_435621_0010, served January 25, 2016 no non-compliance was identified.

6) January 21, 2016, Complaint Inspection # 2016_246196_0002 (A1), served February 12, 2016, and amended on February 25, 2016, non-compliance was identified resulting in five written notifications, including three voluntary plans of correction and three compliance orders.

7) February 11, 2016, Complaint Inspection # 2016_264609_0006, served March 7, 2016, non-compliance was identified resulting in four written notifications, including two compliance orders.

8) March 17, 2016, Complaint Inspection # 2016_246196_0005 (A1), served May 12, 2016, and amended on June 30, 2016, non-compliance was identified resulting in 15 written notifications, including seven voluntary plans of correction, and two compliance orders.

9) March 29, 2016, Follow Up Inspection # 2016_246196_0006 (A1), served May 12, 2016, and amended on June 30, 2016, non-compliance was identified resulting in seven written notifications, including six voluntary plans of correction, one compliance order, and one Director's Referral.

10) March 29, 2016, Critical Incident Inspection # 2016_246196_0007 (A1), served May 12, 2016, and amended on June 30, 2016, non-compliance was identified resulting in five written notifications, including, one voluntary plan of correction, and one compliance order.

11) May 17, 2016, Complaint Inspection # 2016_333577_0011, served July 6, 2016, non-compliance was identified resulting in six written notifications, including two voluntary plans of correction, and three compliance orders.

12) May 17, 2016, Follow Up Inspection # 2016_333577_0010 (A1), served July 6, 2016, and amended on July 13, 2016, non-compliance was identified resulting in five written notifications, including, six compliance orders.

13) July 7, 2016, Resident Quality Inspection # 2016_435621_0012 (A2), served on October 11, 2016, amended on November 25, 2016 and January 06, 2017, non-compliance was identified resulting in 19 written notifications, including 12 voluntary plans of correction and two compliance orders.

14) October 11, 2016, Complaint Inspection # 2016_391603_0023, served November 3, 2016, non-compliance was identified resulting in four written notifications, including one voluntary plan of correction.

15) October 11, 2016, Follow Up Inspection # 2016_391603_0024 (A1), served November 7, 2016 and amended on November 25, 2016, non-compliance was identified resulting in six written notifications, including six compliance orders and four Directors referrals.

16) October 11, 2016, Critical Incident Inspection # 2016_391603_0022 (A1), served November 7, 2016, and amended on November 25, 2016, non-compliance was identified resulting in six written notifications, including three voluntary plans of correction and one compliance order.

17) November 4, 2016, Compliant Inspection # 2016_246196_0019, served January 3, 2017, no non-compliance was identified.

18) January 9, 2017, Critical Incident Inspection # 2017_616542_0003, served February 9, 2017, non-compliance was identified resulting in three written notifications, including three voluntary plans of correction.

19) January 9, 2017, Complaint Inspection # 2017_616542_0001, served February 9, 2017, no non-compliance was identified.

20) January 9, 2017, Follow Up Inspection # 2017_616542_0002 (A1), served February 28, 2017 and amended on March 7, 2017, non-compliance was identified resulting in three written notifications, including three compliance orders.

21) March 21, 2017, Resident Quality Inspection # 2017_624196_0005, served May 16, 2017, non-compliance was identified resulting in 12 written notifications, including five voluntary plans of correction and one compliance order.

22) On August 14, 2017, Critical Incident Inspection # 2017_509617_0017, served October 11, 2017, non-compliance was identified resulting in 17 written notifications, including seven voluntary plans of correction and seven compliance orders.

23) On August 14, 2017, Complaint Inspection # 2017_509617_0018, served October 11, 2017, non-compliance was identified resulting in six written notifications, including five voluntary plans of correction and two compliance orders.

24) On August 14, 2017, Follow-Up Inspection # 2017_509617_0019, served October 11, 2017, non-

compliance was identified resulting in one written notification including one compliance order.

As Director, I am relying on the extensive history of non-compliance outlined in 21 of the inspections reports associated with the 24 inspection listed above. The key areas of non-compliance with Compliance Orders include, but are not limited to the following:

1. **Reporting Certain Matters to Director – LTCHA, s. 24(1)2.** – The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occurred immediately reported the suspicion and the information up which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

- On February 25, 2015, non-compliance was identified resulting in a voluntary plan of correction issued during Resident Quality Inspection # 2015_246196_0016.
- On October 29, 2015, non-compliance was identified resulting in a compliance order issued during Resident Quality Inspection # 2015_333577_0012 (A1). The decision to issue this order was based on a pattern of non-compliance that resulted in actual harm or risk of harm of residents, as well as previous non-compliance in this area of legislation. Pursuant to s. 153(1)(a) of the LTCHA, the licensee was required to ensure that a person who has reasonable grounds to suspect improper treatment or care of a resident that resulted in harm or a risk of harm to the resident has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director. This order was not complied with and it was reissued on February 25, 2016.
- On February 25, 2016, non-compliance was identified resulting in a compliance order reissued during Follow-Up Inspection # 2015_435621_0012 (A1). The decision to reissue this compliance order was based on a pattern of late reporting to the Director and a potential for actual harm, as well as a history of non-compliance with s.24(1). Pursuant to s. 153(1)(a) of the LTCHA, the licensee was required to 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. This order was not complied with and was reissued on June 30, 2016.
- On June 30, 2016, non-compliance was identified resulting in a Director's Referral and compliance order issued during Follow-Up Inspection # 2016_246196_0006 (A1). The decision to reissue this order was based on two residents being affected by the late reporting of abuse resulting in minimum harm or a potential for actual harm. This was the third consecutive compliance order related to s. 24(1). Pursuant to s. 153(1)(a) of the LTCHA, the licensee was required to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director; b) provide training and re-training for all staff related to the mandatory reporting of abuse of a resident that resulted in harm or a risk of harm to the resident and c) maintain records of the contents of the training, the names of the attendees, the names of the educators and the dates of the training. This order was compiled on January 6, 2017.
- On January 6, 2017, the licensee was issued a voluntary plan of correction from Resident Quality Inspection # 2016_435621_0012 (A1) which was conducted July 4-20, 2016. The voluntary plan of correction was issued because the identified non-compliance had occurred prior to an outstanding compliance order due date. Subsequently the compliance order from Follow-Up inspection # 2016_246196_0006, was complied.
- On February 9, 2017, non-compliance was identified resulting in a voluntary plan of correction issued during Critical Incident System Inspection # 2017_246196_ 0003.

- On May 16, 2017, non-compliance was identified resulting in a voluntary plan of correction issued during Resident Quality Inspection # 2017_624196_0005.
- On October 11, 2017, non-compliance was identified resulting in a written notification issued during Critical Incident Inspection # 2017_509617_0017. Findings of non-compliance were included in Compliance Order #002 pursuant to s. 19 (1) of the LTCHA Duty to Protect.
- Despite being issued multiple non-compliances including three previous Compliance Orders and a Director's Referral, the licensee has not ensured and sustained compliance with this requirement under the LTCHA resulting in further harm and risk of harm to residents.

2. **Plan of Care – LTCHA, s. 6(7)** – The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

- On February 25, 2015, non-compliance was identified resulting in a voluntary plan of correction issued during Resident Quality Inspection # 2014_246196_0016.
- On October 29, 2015, non-compliance was identified resulting in a written notification issued during Resident Quality Inspection # 2015_333577_0012 (A1).
- On March 7, 2016, non-compliance was identified resulting in a compliance order issued during Complaint Inspection # 2016_264609_0006. The decision to issue this order was based on a pattern of non-compliance with this area of legislation that resulted in actual harm to a resident. Pursuant to s. 153(1) (a) of the LTCHA, the licensee was required to a) Perform training and retraining of all staff involved in caring for residents on the home's policies and procedures related to isolation precautions. The home will maintain a record of the training and retraining, what the training entailed, who completed the training and when the training was completed. b) Identify all residents of the home who are at high risk of dehydration and audit each resident's fluid record to ensure adequate fluid intake is provided and that it is correctly documented in the resident clinical records. c) Provide training and retraining to all direct care staff of the home to ensure that they provide care as specified in each resident's plan of care and that any revisions to the plan of care are communicated to the appropriate members of the care team, especially related to nursing care measures. The home will maintain a record of the training and retraining, what the training entailed, who completed the training and when the training was completed. d) Provide training and retraining to all direct care staff related to the home's policies, procedures and contingency plans when working with less staff than the regular deployment especially related to filling vacant shifts and redeployment of staff to meet the needs of the residents of the home. The home will maintain a record of the training and retraining, what the training entailed, who completed the training and when the training was completed. This order was not complied with and reissued on July 13, 2016.
- On June 30, 2016, non-compliance was identified resulting in a voluntary plan of correction issued during Complaint Inspection # 2016_246196_0005 (A1). This inspection was conducted prior to the compliance due date of the order issued on March 7, 2016 during Complaint Inspection # 2016_264609_0006.
- On June 30, 2016, non-compliance was identified resulting in a voluntary plan of correction issued during Follow-Up Inspection # 2016_246196_0006 (A1). This inspection was conducted prior to the compliance due date of the order issued on March 7, 2016 during Complaint Inspection # 2016_264609_0006.
- On July 13, 2016, non-compliance was identified resulting in a compliance order issued during Follow-Up Inspection # 2016_333577_0010 (A1). The decision to reissue this compliance order was based on a pattern of non-compliance that resulted in actual harm or risk of harm to a resident. This was also the second reissue of an order related to this area of legislation. Pursuant to s.

153(1)(a) of the LTCHA the licensee was required to a) Provide retaining to all staff involved in caring for residents on the home's policies and procedures related to isolation precautions. This retraining will be specific to additional precautions, contact precautions, droplet precautions, and airborne precautions. The home will maintain a record of the retraining, what the training entailed, who completed the training and when the training was completed. b) Identify all residents of the home who are at risk of dehydration. c) Complete a fluid record audit of those residents' identified, to ensure adequate fluid intake is provided and correctly documented in the resident clinical records. d) Put into place a system to conduct routinely scheduled audits of residents' plans of care to ensure they are providing care as specified in each residents' plan of care. The audit sample shall ensure representation of residents from a variety of home areas and include residents requiring interventions related to falls prevention and management, restraints and responsive behaviours. The audits are to be conducted by registered staff or a member of the home's leadership team. Each audit must be reviewed by a member of the home's leadership team to verify accuracy of the audit, to document actions taken to address specific deficient findings and to document system level changes made in response to the findings. e) Provide retraining to all direct care staff of the home on resident's plan of care and revisions to the plan of care, especially related to nursing care measures. The home will maintain a record of retraining, what the training entailed, who completed the training and when the training was completed. This order was not complied with and reissued on November 25, 2016.

- On November 25, 2016, non-compliance was identified resulting in a Director's Referral and a compliance order issued during Follow-Up Inspection # 2016_391603_0024 (A1). The decision to reissue this order was based on an isolated incident of non-compliance that resulted in actual harm to a resident, as well as this was the third consecutive compliance order issued for this area of legislation. Pursuant to s. 153(1)(a) of the LTCHA the licensee was required to a) review and revise resident #013's plan of care and once completed, communicate the information to all staff caring for resident #013. b) continue to conduct routinely scheduled audits of residents' plans of care to ensure they are providing care as specified in each resident's plan of care. c) complete the retraining to all direct care staff (RNs, RPNs, PSWs) on residents' plan of care and revisions to the plan of care, especially related to nursing measures. d) complete the retraining to all direct care staff related to the home's policies, procedures, and contingency plans when working with less staff than the regular deployment, especially related to filling vacant shifts and redeployment of staff. This order was not complied with and reissued on March 7, 2017.
- On March 7, 2017, non-compliance was identified resulting in a compliance order issued during Follow-Up Inspection # 2017_616542_0002. The decision to reissue this order was based on widespread non-compliance that resulted in a potential for actual harm to a resident, as well as this was the fourth consecutive compliance ordered issued for this area of legislation. Pursuant to s. 153(1)(a) of the LTCHA the licensee was required to a) provide retraining for all direct care staff, specifically the Personal Support Workers (PSWs), regarding all residents' plan of care and revisions to the plan of care, related to nursing measures. b) Ensure resident #011's plan of care is followed specifically related to the physician's wound care orders. c) Ensure resident #008's plan of care is followed as per the resident's care needs, specifically but not limited to their continence care assistance, restraint monitoring and repositioning. This order was complied with on May 16, 2017, during Resident Quality Inspection # 2017_624196_0005.
- On October 11, 2017, non-compliance was identified resulting in a compliance order issued during Complaint Inspection # 2017_509617_0018. The decision to issue this order was based on a pattern of five residents not receiving the care they required related to one of the following: their activities of daily living, fall prevention or responsive behaviour interventions. There was actual

harm to four of the residents and the licensee continues with non-compliance in this area of the legislation. Pursuant to s. 153(1)(a) of the LTCHA the licensee was ordered to ensure that care set out in the plan of care is provided to 1) resident #028 regarding their activities of daily living care provision, 2) resident #003 regarding their fall prevention interventions, 3) resident #004 regarding their fall prevention interventions, 4) resident #037 regarding their responsive behaviour interventions, 5) resident #034 regarding their responsive behaviour interventions, and 6) to all other residents in accordance with their plan of care. The compliance due date is December 1, 2017.

- Despite being issued multiple non-compliances, including five previous Compliance Orders and a Director Referral, the licensee has not ensured and sustained compliance with s. 6(7) of the LTCHA.

3. **Policy to promote zero tolerance – LTCHA, 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.

- On February 25, 2016, non-compliance was identified resulting in a compliance order issued during Follow-Up Inspection # 2015_435621_0012 (A1). The decision to issue the order was based on a pattern of non-compliance with this legislation that resulted in actual harm to residents. Pursuant to s. 153(1)(a) of the LTCHA the licensee was required to: 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. This order was not complied with and reissued on July 13, 2016.
- On June 20, 2016, non-compliance was identified resulting in a voluntary plan of correction issued during Follow-Up Inspection # 2016_246196_0006 (A1). This inspection was conducted prior to the compliance due date of the order issued on March 31, 2016 during Follow-Up Inspection # 2015_435621_0012 (A1).
- On July 13, 2016, non-compliance was identified resulting in a compliance order issued during Follow-Up Inspection # 2016_333577_0010 (A1). The decision to reissue this compliance order was based on a pattern of non-compliance related to training of the home's policy promoting zero tolerance of abuse and neglect which resulted in minimal harm or potential for actual harm of residents, as well as a history of a compliance order with this legislation. This was also the second reissue of an order related to this area of legislation. Pursuant to s. 153(1)(a) of the LTCHA the licensee was required to provide retraining to all direct care staff on the home's revised policy titled "Zero Tolerance of Abuse and Neglect of Residents" and ensure that the policy is complied with. The home will maintain a record of the retraining, what the training entailed, who completed the training and when the training was completed. This order was not complied with and reissued on November 25, 2016.
- On November 25, 2016, non-compliance was identified resulting in a voluntary plan of correction issued during Resident Quality Inspection # 2016_435621_0012 (A1). This inspection was conducted prior to the compliance due date of the order issued on July 13, 2016 during Follow-Up Inspection # 2016_333577_0010 (A1).
- On November 25, 2016, non-compliance was identified resulting in a Director's Referral and a compliance order issued during Follow-Up Inspection # 2016_391603_0024 (A1). The decision to issue this order was based on widespread non-compliance that resulted in a potential for actual harm to residents, as well as previous compliance orders with this legislation. This was also the

third reissue of an order related to this area of legislation. Pursuant to s. 153(1)(a) of the LTCHA the licensee was required to retrain all direct care staff on the home's revised policy titled "Zero Tolerance of Abuse and Neglect of Residents". This order was complied on March 7, 2017, during Follow-Up Inspection # 2017_616542_0002 (A1).

- On October 11, 2017, non-compliance was identified resulting in a written notification issued during Critical Incident Inspection # 2017_509617_0017. Findings of non-compliance were included in Compliance Order #002 pursuant to s. 19 (1) of the LTCHA Duty to Protect.
- Despite being issued multiple non-compliances including three previous Compliance Orders and a Director's Referral, the licensee has not ensured and sustained compliance with s. 20(1) of the LTCHA.

4. **24-hour admission care plan - O. Reg. 79/10, s. 24(1)** – Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home**. O. Reg. 79/10, s. 24(3)** – The care plan must identify the resident and must include, at a minimum, the following with respect to the resident: 1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. **O. Reg. 79/10, s. 24(3)** – The licensee shall ensure that the care plan sets out, (a) the planned care for the resident; and (b) clear directions to staff and others who provide direct care to the resident.

- On February 25, 2016, non-compliance was identified resulting in a compliance order issued during Complaint Inspection # 2016_246196_0002 (A1). The decision to issue this order was based on a pattern of non-compliance that resulted in potential harm to residents. Pursuant to s. 153(1)(a) of the LTCHA the licensee was required to ensure that the 24-hour admission care plan set out clear directions to staff and others who provide direct care to the resident. The licensee shall: (a) ensure the 24-hour admission care plans and subsequent plans of care for residents in the home, set out clear directions to staff. (b) Ensure that the information regarding restraint use is clearly indicated on these plans under the applicable category. (c) Provide training to those staff who are completing the 24-hour admission care plans to ensure resident information is accurate. This order was not complied with and reissued on July 13, 2016.
- On July 13, 2016, non-compliance was identified resulting in a compliance order issued during Follow-Up Inspection # 2016_333577_0010 (A1). The decision to reissue this order was based on a pattern of non-compliance which resulted in minimal harm or potential for actual harm to residents, as well as a history of non-compliance with this legislation. This was also the second reissue of an order related to this area of legislation. Pursuant to s. 153(1)(a) of the LTCHA the licensee was required to: (a) Put into place a system to conduct routinely scheduled audits of 24-hour admission care plans to ensure they are providing clear direction in each residents' plan of care and subsequent plans of care. The audit sample shall ensure representation of residents from a variety of home areas and include residents requiring interventions related to restraints. The audits are to be conducted by registered staff or a member of the home's leadership team. Each audit must be reviewed by a member of the home's leadership team to verify accuracy of the audit, to document actions taken to address specific deficient findings and to document system level changes made in response to the findings. (b) Provide retraining to all direct care staff of the home on 24-hour admission care plans, especially related to nursing care measures. The home will maintain a record of retraining, what the training entailed, who completed the training and when the training was completed. This order was not complied with and reissued on November 25, 2016.
- On November 25, 2016, non-compliance was identified resulting in a Directors Referral and a compliance order reissued during Follow-Up Inspection # 2016_391603_0024 (A1) as this was the

third reissue of an order related to this area of legislation. The decision to reissue this order was based on widespread non-compliance which resulted in a potential of actual harm to residents. Pursuant to s.153(1)(a) of the LTCHA the licensee was required to: (a) conduct routinely scheduled audits of 24-hour admission care plans to ensure they are providing clear direction in each resident's plan of care and subsequent plans of care, and once the audits are completed, members of the leadership team must review some of the audits for accuracy. (b) Retrain all direct care staff (RNs, RPNs, and PSWs) on 24-hour admission care plans, especially related to nursing care measures. This order was not complied with and reissued on March 7, 2017.

- On March 7, 2017, non-compliance was identified resulting in a compliance order issued during Follow-up Inspection # 2017_616542_0002 (A1). The decision to reissue this order was based on widespread non-compliance that resulted in a potential for actual harm to residents. This was also the fourth consecutive compliance order issued for this area of legislation and a Directors Referral had previously been issued. Pursuant to s. 153(1)(a) of the LTCHA the licensee was required to ensure that all direct care staff were provided with retraining on all 24-hour admission care plans, specifically related to nursing care measures. This order was complied on May 16, 2016, during Resident Quality Inspection # 2017_624196_0005.
- On October 11, 2017, non-compliance was identified resulting in a written notification issued during Critical Incident Inspection # 2017_509617_0017. Findings of non-compliance were included in Compliance Order #002 pursuant to s. 19 (1) of the LTCHA Duty to Protect.
- Despite being issued multiple non-compliances including four previous Compliance Orders and a Director Referral, the licensee has not ensured and sustained compliance with s. 24 of the Regulation.

5. **Duty to Protect - LTCHA, s. 19(1)** – Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

- On October 29, 2015, non-compliance was identified resulting in a compliance order issued during Resident Quality Inspection # 2015_33577_0012 (A1). The decision to issue the order was based on actual harm or risk of harm to one resident, as well has the home's previous compliance history with this legislation. Pursuant to s. 153(1)(a) of the LTCHA the licensee was required to ensure that resident #025 was protected from abuse by anyone. This order was complied on February 25, 2016, during Follow-Up Inspection #2015_435621_0012 (A1).
- On January 6, 2017, non-compliance was identified resulting in a compliance order issued during Resident Quality Inspection # 2016_435621_0012 (A1). The decision to issue the order was based on non-compliance affecting multiple residents that resulted in actual harm, as well as previous non-compliance with this area of the legislation. Pursuant to s. 153(1)(a) of the LTCHA the licensee was required to ensure that residents of the home were protected from abuse by anyone. This order was complied on March 7, 2017, during Follow-Up Inspection # 2017_616542_0002 (A1).
- On November 25, 2016, non-compliance was identified resulting in a voluntary plan of correction issued during Critical Incident Inspection # 2016_391603_0022 (A1). This inspection was conducted prior to the compliance due date of the order issued on January 6, 2017 during Resident Quality Inspection # 2016_435621_0012 (A1).
- On October 11, 2017, non-compliance was identified resulting in a compliance order issued during Critical Incident Inspection #2017_509617_0017. The decision to issue this order was based the licensee's ongoing non-compliance with this section of the legislation, affecting multiple residents that resulted in actual harm. Included in Compliance Order #002, findings of non-compliance

issued as written notifications related to LTCHA s. 20 – compliance with the policy to promote zero tolerance of abuse, s.23 – licensee must investigate, respond and act, s. 24 – reporting certain matters to the Director, s. 76 (2) – orientation training and O.Reg 79/10 s. 104 – submitting a written report within 10 days to the Director. Pursuant to s. 153(1)(a) of the LTCHA the licensee was ordered to ensure that 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: i) improper or incompetent treatment of a resident that resulted in harm or a risk of harm to the resident. ii) 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. iii) unlawful conduct that resulted in harm or a risk of harm to a resident. iv) misuse or misappropriation of a resident's money. x) misuse or misappropriation of funding provided to a licensee under this Act or the *Local Health System Integration Act*. 2) The home's written policy to promote zero tolerance of abuse is reviewed and revised to ensure it complies with the requirements of the LTCHA and O.Reg 79/10, and is complied with. 3) appropriate action is taken in response to every incident of alleged, suspected or witnessed abuse or a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations. This order is to be complied on December 1, 2017.

- Despite being issued non-compliances including three previous Compliance Orders, the licensee has not managed to ensure compliance with s. 19 of the LTCHA.

6. **Recent Complaint, Critical Incident and Follow-Up Inspections** conducted in August 2017.

- During these three concurrent inspections a large number of complaints and critical incidents were inspected as well as a Follow-Up to one order. The non-compliance found during these concurrent inspections are related to:
- 24-plan of care
- Plans of Care (multiple areas)
- Failing to report abuse
- Staff not following the home's abuse policy
- Failing to report results of abuse investigations to the Director
- Training
- Falls prevention, specifically not following the home's fall prevention program and not conducting post falls assessments
- Improper transferring resulting in injury to resident
- Responsive Behaviour Program not being evaluated as required
- Insufficient staffing to meet residents' needs and the home's staffing plan does not address continuity of staff
- Maintenance of the home specific to roam alert not functioning
- Security of Drug supply related to unlocked med cart
- Specific doors in the home kept closed and locked
- Communication and Response System being easily seen and accessible
- Pain management, specifically a resident being assessed when pain was not relieved by initial interventions
- Infection Prevention and Control
- Skin and Wound assessments being conducted weekly
- Weight changes

Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Inspections Branch

Ministère de la Santé et des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

This order must be complied with by:	November 30, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
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.

Issued on this 12 day of October, 2017.	
Signature of Director:	
Name of Director:	Karen Simpson

Version date: 2017/02/15