Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 18, 2017	2017_633577_0021	025220-17	Complaint

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

DEBBIE WARPULA (577)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 8 and 9, 2017

The following intakes were inspected:

One Complaint submitted to the Director related to resident safety and privacy breach; and

One Critical Incident System (CIS) report submitted by the home related to a resident privacy breach.

During the course of the inspection, the inspector conducted a tour of one resident home area, observed the delivery of care to residents, observed staff to resident interactions, reviewed resident health care records, reviewed home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Security Supervisor, Clinical Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Security guards and one resident.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dignity, Choice and Privacy

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A Complaint was received by the Director in November 2017, which alleged that resident #001 was seen on a social media site via video, running into traffic.

On November 8, 2017, Inspector #577 reviewed the video, which revealed resident #001 to have run into oncoming traffic and jumped on two vehicles.

Inspector #577 reviewed resident #001's progress notes on November 8, 2017, and found five documented incidents where resident #001 had left the home and was later transferred to an acute care facility for treatment.

A review of the physician's orders revealed a current order for a leave of absence which did not contain any restrictions.

Inspector #577 reviewed resident #001's care plan on the morning of November 8, 2017, and found that there were no specific focus or interventions that addressed resident #001's extended absences from the home that involved a specific behaviour or interventions for staff to monitor the resident's leaves of absence.

Inspector #577 reviewed resident #001's care plan which was updated on the afternoon of November 8, 2017, which indicated a focus and interventions for the specific behaviour.

During an interview with RPN #101 on November 8, 2017, they reported to the Inspector that resident #001 was independent to leave the home on outings, sometimes they would not sign out when they left the unit, and they would leave frequently to go outside. They further reported that staff monitored the resident by frequent room checks.

During an interview with PSW #102 on November 8, 2017, they reported that the resident would frequently go outside and that staff had not monitored the length of time that they were absent.

During an interview with RN #103 on November 8, 2017, they reported that resident

#001 had a history of participating in a specific behaviour and leaving the home. They further reported that staff would become alarmed if the resident had not returned around lunch time.

During an interview with RPN #104 on November 8, 2017, they reported to the Inspector that the resident would come and go off the unit. They further reported that resident #001's whereabouts were not monitored by staff and that the staff would not be aware if the resident were absent for a long period of time.

Inspector #577 reviewed the home's policy titled "Plan of care – LTC 2-20" last revised February 2016, indicated that the plan of care was reviewed and revised according to reassessment in collaboration and consent with the resident/Substitute Decision Maker (SDM), at a minimum quarterly and with any change in condition, risk level or functional ability.

Inspector #577 spoke with the Acting Director Of Care (ADOC) #107 on November 9, 2017, and together with the Inspector, reviewed the care plan in place on November 8, 2017. They confirmed that the care plan did not include any details concerning resident #001's propensity to engage in a specific behaviour or interventions for staff to monitor resident's absences. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan are no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

A Complaint was received by the Director in November 2017, which alleged that resident #001's personal health information was accessible on a social media site. Further details of the complaint report confirmed that an employee from the security department had posted resident #001's name and indicated that they were a resident of the long-term care home.

A Critical Incident System report was received by the Director in November 2017, which alleged a breach of confidentiality concerning resident #001. The report further indicated that a video of resident #001 had been posted on a social media site and that an employee from the security department had posted a comment that identified resident #001 by name and residence of the long-term care home.

Inspector #577 spoke with RN #105 on November 8, 2017, who reported that they received a call from the complainant in November 2017, who reported that security guard #100 had posted resident #001’s name and identified them as a resident of the home on a social media site. Further, they received a video with a posted comment made by security guard #100 that identified resident #001 by name and their place of residence.

On November 9, 2017, Inspector #577 reviewed the home’s policy titled "Privacy of Personal Health Information - AD 6-105" last revised September 1, 2016, which defined the Right of Privacy as a person's right to be free of unwarranted public scrutiny or exposure. Confidentiality referred to organizational or professional duties with respect to limiting disclosure or improper use of information without authorization.

On November 9, 2017, Inspector #577 reviewed Safety Net Security’s policy titled “Social Networking Sites and Blogs” which indicated that employees that used social networking sites were prohibited from disseminating any workplace incidents or accidents. The policy was also signed by security guard #100, which acknowledged agreement of adhering to the policy, dated June 2017.

During a review of the home’s investigation file and interview with the ADOC #107 on November 9, 2017, it was confirmed that security guard #100 had posted resident #001’s name, identified them as a resident of the home on a social networking site, and breached confidentiality.

On November 10, 2017, Inspector #577 spoke with Security Supervisor #106 who confirmed that security guard #100 had posted personal information of resident #001 on a social media site, which identified them by name, and place of residence and should not have.

On November 14, 2017, Inspector #577 spoke with security guard #100 who confirmed that they did post personal information concerning resident #001 on a social networking site, which identified the resident by name and place of residence and should not have. They also confirmed that their action was breaching confidentiality. [s. 3. (1) 11. iv.]

Issued on this 20th day of December, 2017

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

Original report signed by the inspector.