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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 22, 2018	2018_655679_0005	001636-18, 001713-18, 002935-18, 003133-18, 003268-18, 003641-18, 003738-18, 003781-18, 003866-18, 004199-18, 004425-18, 004765-18	Critical Incident System

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

MICHELLE BERARDI (679), JENNIFER BROWN (647), JENNIFER LAURICELLA (542), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 12 - March 15, 2018.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:

- Three intakes related to resident elopement,

- One intake related to a resident fall,

- Four intakes related to abuse and neglect,

- Two intakes related to the infection prevention and control program; and,

- One intake related to the administration of medication.

A Complaint inspection #2018_655679_0006 and a Follow Up inspection #2018_655679_0007 were conducted concurrently with this CIS inspection

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Director of Care (ADOC), Clinical Managers, Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs),
Security Guards, family members and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, home's internal investigation notes, staff education records, as well as reviewed numerous licensee policies, procedure and programs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **0 VPC(s)**
- **1 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy to promote zero

tolerance of abuse and neglect, and that the policy was complied with.

A Critical Incident (CI) report was submitted to the Director for an incident of alleged staff to resident neglect. The CI report identified that PSW #115 performed an action which jeopardized resident #011's safety.

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

Inspector #679 reviewed the Extendicare policy entitled "Zero Tolerance of Resident Abuse and Neglect Program (RC-02-01-01)" last revised April 2017. The policy identified examples of neglect that included, but were not limited to: lack of necessary safety precautions to prevent injury to the resident.

A review of the electronic progress notes identified that resident #011 experienced injury following the incident.

In an interview with RN #126 they identified that they had responded to the incident. RN #126 indicated that the home had reviewed the video footage which depicted that PSW #115 performed an action which jeopardized resident #011's safety.

In an interview with Clinical Manager #124 they indicated that PSW #115 performed an action which jeopardized resident #011's safety. Clinical Manager #124 indicated that PSW #115 did not follow the home's policy for zero tolerance of abuse and neglect as they neglected to keep the resident safe.

2. A CI report was submitted to the Director for an incident of alleged staff to resident abuse. According to the CI report, PSW #104 performed care improperly while assisting resident #002. Resident #002 requested for the care to be stopped, to which PSW #103 responded an inappropriate comment.

Inspector #543 reviewed the Extendicare policy entitled "Zero Tolerance of Resident Abuse and Neglect Program" (RC-02-01-01), last updated April 2017. The policy identified examples of emotional abuse that included but were not limited to the following; any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks that were performed by anyone other than a resident. The policy identified

examples of verbal abuse that included but were not limited to the following; any form of verbal communication of threatening or intimidating nature, any form of verbal communication of belittling or degrading nature which diminished the resident's sense of well-being.

Inspector #543 reviewed the home's internal investigation documents which indicated that based on the evidence obtained during their investigation, PSW #103 had performed improper care towards resident #002, despite the resident's protest. The document identified that PSW #103 knowingly caused the resident discomfort and failed to care for them with dignity and respect, and that their behaviour constituted abuse of the resident.

Inspector #543 reviewed the home's internal investigation documents which indicated that based on the evidence obtained during their investigation, PSW #104, had proceeded in assisting with improper care, despite the resident's protest. The document identified that PSW #104 knowingly caused the resident discomfort and failed to care for them with dignity and respect, and that their behaviour constituted abuse of the resident.

Inspector #543 interviewed Clinical Manager #124 who verified that the actions taken by PSW #103 and #104 constituted verbal, emotional and physical abuse towards resident #002. They indicated that both PSWs had not complied with the home's "Zero Tolerance of Resident Abuse and Neglect Program" (RC-02-01-01).

Additional Required Actions:

CO # - 001 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home submitted a Critical Incident (CI) which indicated that there had been an incident that caused injury to resident #005 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of the above mentioned CI report indicated that resident #005 had been found on the floor with an injury. Resident #005 had sought medical attention.

A clinical record review indicated that resident was at a specific level of risk for falls, transferred with a specified level of assistance, and required a specified level of assistance with activities of daily living.

A review of the electronic care plan identified that resident #005 was to be checked on during specified intervals for comfort and safety. Additionally, the care plan identified that staff were to provide a specified intervention to resident #005 for fall prevention.

An interview with RPN #100 who had worked at the time of the incident indicated that resident #005 had been required to be checked for safety at a specified interval. RPN #100 further indicated that resident #005 was observed at a particular time.

In an Interview with PSW #101 who had worked at the time of the incident, they indicated that they had been responsible for completing a specified intervention for all residents. When asked if the above mentioned PSW provided resident #005 with their intervention, PSW #101 indicated that they forgot to stop at their room, however passed their room and provided the intervention to all other residents.

During an interview with PSW #102, they indicated that they had been responsible for the care of resident #005 on the day of the incident. PSW #102 further indicated that all residents were to be checked on at specified intervals to ensure safety and to ensure their needs were met. PSW #102 indicated however, that on the date the incident, they did not check on resident #005 on the specified intervals and resident #005 would have gone for a number of hours without having a safety check.

The DOC acknowledged during the above mentioned interview that resident #005 had been neglected when PSW #102 knew their responsibility had been to check on resident #005 at specified intervals for safety and had not checked on resident #005 for a number of hours. In this period of time, resident had fallen in their room, sustained an injury and sought medical attention.

A compliance order (CO) #001 was issued during inspection #2017_509617_0018 with a compliance due date of February 28, 2018, and this finding will serve as grounds to support CO #001. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A CI report was submitted to the Director, related to a missing or unaccounted for controlled substance. The CI report identified that four medication errors had occurred involving controlled substances.

A review of the home's policy titled, "Narcotic and Controlled Drug Control" dated February 2017, was completed by Inspector #542. It was documented on the policy that the narcotic records were to be completed appropriately by the registered staff, all documentation was to be legible and that each entries were to be scanned to ensure they were appropriate.

Inspector #542 completed a review of the home's investigation notes regarding the medication errors that were completed by RPN #128. RPN #128 was provided with a "Letter of Counsel" that outlined that they did not follow the proper procedure for signing out narcotics as indicated in their "controlled substance and narcotic" policy. In an interview with the ADOC #116 they indicated that RPN #128 had received a letter of counsel.

Issued on this 22nd day of March, 2018

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

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE BERARDI (679), JENNIFER BROWN (647), JENNIFER LAURICELLA (542), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2018_655679_0005
Log No. / No de registre :	001636-18, 001713-18, 002935-18, 003133-18, 003268-18, 003641-18, 003738-18, 003781-18, 003866-18, 004199-18, 004425-18, 004765-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 22, 2018
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, P.O. Box 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Hogarth Riverview Manor 300 Lillie Street, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Judy Plummer

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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Order / Ordre :

The licensee must be compliant with s. 20 of the LTCHA.

Specifically, the licensee must:
a) ensure residents #002 and #011, and all other residents, are protected from abuse and neglect by staff.
b) ensure PSW #103 and PSW #104 review the home's policy entitled "Zero Tolerance of Resident abuse and Neglect Program". This process should be documented.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written policy to promote zero tolerance of abuse and neglect, and that the policy was complied with.

A Critical Incident (CI) report was submitted to the Director for an incident of alleged staff to resident neglect. The CI report identified that PSW #115 performed an action which jeopardized resident #011's safety.

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

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Inspector #543 interviewed Clinical Manager #124 who verified that the actions taken by PSW #103 and #104 constituted verbal, emotional and physical abuse towards resident #002. They indicated that both PSWs had not complied with the home's "Zero Tolerance of Resident Abuse and Neglect Program" (RC-02-01-01).

The severity of this issue was determined to be a level three, as there was actual harm to the residents of the home. The scope of this issue was a level two, as it affected more than the fewest number of residents in the home. The home had a level four compliance history as they had ongoing non-compliances with this section of the LTCHA that included:

- written notification (WN) issued February 2, 2018, (2018_657681_0001);

- voluntary plan of correction (VPC) issued November 14, 2017, (2017_509617_0020);

- WN issued October 11, 2017, (2017_509617_0017);

- Director Referral (DR) #002, issued November 7, 2016, with a compliance due date (CDD) of December 31, 2016, (2016_391603_0024);

-VPC issued October 11, 2016, (2016_435621_0012);

-compliance order (CO) #002 issued July 6, 2016, with a CDD of September 30, 2016, (2016_333577_0010);

-VPC issued May 12, 2016, (2016_246196_0006);

-CO #004 issued February 16, 2016, with a CDD of March 31, 2016, (2015_435621_0012) (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of March, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Michelle Berardi

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