Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 20, 2019	2019_746692_0019	022982-18, 005445-19, 005611-19, 006107-19, 007163-19, 007197-19, 007998-19, 008966-19, 009435-19, 009886-19, 010707-19, 011247-19, 011308-19, 011508-19, 011748-19, 011813-19, 012052-19, 012587-19, 012847-19, 013191-19, 013206-19, 014491-19	Critical Incident System

Licensee/Titulaire de permis

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

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

Hogarth Riverview Manor
300 Lillie Street THUNDER BAY ON P7C 4Y7

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

SHANNON RUSSELL (692), AMANDA BELANGER (736), AMY GEAUVREAU (642), STEPHANIE DONI (681), STEVEN NACCARATO (744)

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): July 15-19 and 22-26, 2019.

The Following intakes were inspected upon during this Critical Incident Inspection:
-One log, which was related to a critical incident that the home submitted to the Director related to an allegation of resident neglect;
-Two logs, which were related to critical incidents that the home submitted to the Director related to incidents of improper care of residents;
-Three logs, which were related to critical incidents that the home submitted to the Director regarding incidents of resident to resident sexual abuse;
-Five logs, which were related to critical incidents that the home submitted to the Director related to missing residents;
-Five logs, were related to critical incidents that the home submitted to the Director regarding injuries to residents that resulted in a transfer to hospital; and
-Six logs, which were related to critical incidents that the home submitted to the Director in relation to incidents of resident to resident physical altercations.

A Complaint inspection #2019_746692_0018 was conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance of a Voluntary Plan of Correction (VPC) related to s. 6 (1) (a) and s. 6 (4) (a), and s. 6 (7) of the LTCHA 2007, were identified in this inspection and have been issued in Inspection Report, # 2019_746692_0018, dated August 20, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care(s) (DOCs), Clinical Manager(s) (CMs), Resident Social Worker (RSW), Medical Director (MD), Therapeutic Recreationist (TR), Corporate Educator, Resident Assessment Instrument-Coordinator (RAI-C), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), 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 and resident to resident interactions, reviewed relevant health care records, internal investigation notes, complaint logs, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Sexual abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

a) A Critical Incident System (CIS) report was submitted to the Director, on an identified date, as Personal Support Worker (PSW) #135 had reported an alleged sexual abuse involving resident #015 towards resident #019, who stated that resident #015 had exhibited a responsive behaviour of a sexual nature towards them in an identified area of the unit.

Inspector #642 reviewed resident #019's electronic progress notes on Med-e-care, and identified three progress notes, documented by three different nurses, Registered Practical Nurse (RPN) #134, Registered Nurse (RN) #140 and #141. They had documented that resident #015 had been in an identified area of the unit, when resident #019 had identified resident #015 as the one who had exhibited a responsive behaviour of a sexual nature towards them, and that they had been upset about it, and wanted the authorities notified.

Inspector #642 reviewed resident #015's care plan, in effect at the time of the incident, and under an identified focus, resident #015 had a history of exhibiting responsive behaviours of a sexual nature towards others, and was identified as requiring an identified intervention at all times.

Inspector #642 reviewed the home's policy titled, "Zero Tolerance of resident Abuse and Neglect Program," last revised on April 2017. The policy defined sexual abuse as, "any non-consensual touching, behaviour, or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

Inspector #642 interviewed the PSW #130, who completed the identified intervention for resident #015, on the identified date. The PSW stated resident #015 had requested the PSW complete an action for them. and that PSW #130 thought it would be safe, so they ceased the identified intervention. The PSW stated that when they went to commence the identified intervention again, resident #015 was no longer in the location that they had been in, and they had to go look for them. PSW #130 stated they had found resident #015 in an area of the unit in the close proximity of resident #019, and that resident #019 was really upset. The PSW stated they had not seen what resident #015 was doing,

since they could only see their back side. PSW #130 stated that they re-directed the resident to a different location.

Inspector #642 separately interviewed PSW #135, and #151, who were proving resident care together for resident #019, when resident #019 stated, that another resident had exhibited a responsive behaviour of a sexual nature towards them. The PSW's stated that at first they were not sure what had happened, or who had exhibited the responsive behaviour towards resident #019. They had informed the nurse at that time of what they had been told by resident #019.

Inspector #642 had interviewed RPN #134, who had documented the first progress note about the incident, and they stated they had informed CM #166, who stated they would review the units video footage.

The Inspector had reviewed the home's investigation notes, and reviewed the description of the video footage documented by Clinical Manager (CM) #166, which chronologically described when the identified intervention was stopped, and the location that resident #015 had gone.

When Inspector #642 interviewed PSW #151, they stated that when they were assisting resident #019 on the unit, they had pointed to resident #015 as the resident that exhibited a responsive behaviour of a sexual nature towards them, and they wanted the authorities contacted. PSW #151 stated that they were also with resident #019 when they told the authorities of the events that had taken place.

Inspector interviewed the Resident Assessment Instrument Coordinator (RAI-C) #167, who identified in resident #015's care plan, under an identified focus that resident #015 was to have an identified intervention at all times.

b) A CIS report was submitted to the Director on an identified date, which alleged a sexual abuse incident involving resident #015, whereby they exhibited a responsive behaviour of a sexual nature towards resident #030.

Inspector #642 reviewed the Med-e-care electronic progress notes, for an identified date, for resident #030, and identified in the notes that resident #015 had exhibited a responsive behaviour of a sexual nature towards resident #030 during a recreational activity at a public area of the home, and the resident had been very upset. Resident #030 quickly intervened to stop the responsive behaviour, and walked away from the

area. The primary nurse assessed resident #030, and they stated they were very "furious" about the incident.

The Inspector reviewed the home's investigation notes, and when resident #030 was interviewed on the date of the incident, resident #030, stated they were angry, taken off guard, and no longer felt safe in the home.

Inspector #642 interviewed resident #030, who stated that they sat down in the public area of the home, sitting by resident #015. They stated that the incident happened so fast, and that they do not feel safe in the home at this time, and they were still visibly upset about the incident.

Inspector #642 interviewed Therapeutic Recreationist (TR) #160, who had been in the area at the time of the incident, and had assisted resident #030 after the incident occurred. The TR stated they had been sitting behind residents #015 and #030, when suddenly they observed resident #030 leave the area, appeared upset. TR #160 stated that resident #030 told them, that resident #015 had exhibited a responsive behaviour of a sexual nature towards them, when they assisted resident #030 back to their room. TR #160 stated that the resident had an identified intervention in place for previous incidents of responsive behaviour of a sexual nature towards others, but they were not completing the identified intervention at the time of the incident.

Inspector #642 interviewed PSW #120, who had been providing the identified intervention for resident #015 on the identified date. PSW #120, stated they had not seen the incident between resident #015 and resident #030, because they were in an area that they were unable to observe the residents. The PSW had seen resident #030 "storm off", and asked TR #160 what had happened, and at that time it was reported that resident #015 had exhibited a responsive behaviour of a sexual nature towards resident #030.

Inspector #642 interviewed the Administrator, who stated that identified intervention should have been completed for resident #015, at all times. When the identified intervention was to be in place at all times, in order to keep other residents safe, and they did not do that.

O Reg 79/10, s. 53 (4)(c), of the LTCHA (2007), was also isued in relation to this finding. Refer to WN #2, finding #4 for details. [s. 19. (1)]

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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident that demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions were documented.

A CIS report was submitted to the Director related to a fall with injury on an identified date. The CIS report indicated that resident #025 had returned from a Leave of Absence (LOA), and began to exhibit an identified responsive behaviour. The resident sustained a fall, when they began to exhibit the identified responsive behaviour.

A review of resident #025's electronic health care records by Inspector #736, identified a progress note, dated with an identified date, documented by RN #142, that indicated that staff were to complete an identified document for resident #025. A further review of the resident's records, by the Inspector, identified a physician's order, dated with an identified date, that indicated that the resident was to have the identified document completed for seven days.

The Inspector located the DOS document for resident #025, for a 14 day period, in the resident's paper chart. Of the 14 days on the sheet, nine of the 24-hour time periods were blank, and had no documentation. Of the other five days, the following entries were blank:
-the first date, for a period of 14 hours;
-the second date, for a period of 16 hours;
-the third and fourth dates, for a period of 8 hours; and,
-the fifth date, for a period of 16 hours.

In an interview with RN #143, they indicated to Inspector #736, that the identified document would be initiated for a resident at times as a nursing measure to determine patterns for a resident with responsive behaviours. The RN further indicated that at times the physician would order the staff to complete the identified document for a resident if they were demonstrating responsive behaviours. The RN indicated to the Inspector that the identified document was considered to be part of the resident's plan of care, and once initiated it was to be completed in its entirely, with no blank spaces. Together, RN #143 and the Inspector, reviewed the physician's order for resident #025, which described that the resident was to have had the identified document initiated. Then, together, the RN and Inspector, reviewed the identified documents for resident #025 for a 14 day period. RN #143 confirmed that care had not been documented, as set out in the plan of care.

In separate interviews with Inspector #736, CM #152 and Director of Care (DOC) #138, indicated that the identified document would be initiated for residents who displayed responsive behaviours as either a nursing measure, or as a physician's order. The CM and the DOC both, indicated that the identified document should have been filled out in its entirety, Together, both the CM and the DOC, reviewed the identified documents with the Inspector for resident #025 for the selected 14 day period, and indicated that the identified document was not filled out in its entirety. The CM and the DOC both indicated that the care for resident #025 was not documented as set out in the plan of care related to the identified document, and it should have been. [s. 53. (4) (c)]

2. The home submitted a CIS report to the Director, which indicated that resident #006 had exhibited a responsive behaviour towards resident #010. The CIS report further indicated that when resident #006 exhibited the responsive behaviour towards resident #010, they sustained an injury.

Inspector #744 reviewed the physician's orders, dated with an identified date, for

residents #006 and #010, which instructed nursing staff to complete the identified document for two weeks, as a result of the incident.

Inspector #744 reviewed the identified document initiated on an identified date, and found the following missing documentation for residents #006 and #010:
-for three consecutive days - no documentation for a five hour period; and,
-No documentation for week two observations.

During an interview with PSW #148, the identified document was reviewed together with Inspector #744. PSW #148 indicated that they were working on the shifts when the documentation was missing. They further indicated that normally "[it was] a team effort" to have the identified document completed for the identified time intervals, and it may have been forgotten.

During an interview with RPN #134, they indicated to Inspector #736 that the need for the identified document for each resident was to be communicated to staff during the RPN shift report. If the PSWs did not complete the identified document, then RPNs would ensure it was completed. RPN #134 also indicated that they believed that the missing documentation for residents #006 and #010 was because staff had forgotten to document.

In an interview with CM #149, they indicated that they could not locate the missing documentation the identified document, and was not aware of any reason why there was inconsistent documentation. CM #149 confirmed that the identified document had not been fully completed for the specified time intervals for residents #006 and #010, as per their expectation. [s. 53. (4) (c)]

3. A CIS report was submitted to the Director on an identified date, in which there was an allegation of physical abuse, involving resident #027 towards resident # 028, resulting in a fall of resident #028.

Inspector #642 identified under the Physicians order for resident #027, on the date of the incident, a physician order, which indicated for staff to initiate the identified document.

The Inspector also observed in the electronic medical notes, in Med-e-care, on an identified date, a progress note, which stated, the identified document was initiated, documented by RPN #114.

Inspector #642 reviewed resident #027's paper medical file binder and identified missing documentation on the identified document:
-Dated: a seven day observation when the identified document had been initiated, and there was documentation missing for the following:
-the first date, for a period of eight hours;
-the second and third dates, for a period of an hour;
-the fourth date, for a period of eight hours;
-the fifth date, for a period of 16 hours.
-Dated: another seven day observation when the identified document was completed for resident #027 and documentation was missing for the following:
-the first date, for a period of 14 hours;
-the second date, for a period of eight hours;
-the third, fourth and fifth dates, for a period of 15 hours; and,
-the sixth and seventh dates, the entire day was missing;

Inspector #642 interviewed PSW #108, and #112, who identified that PSWs were required to complete the identified document when initiated. PSW #120, and RPN #134, also identified that when the identified document was started for residents, it was a requirement that the documentation was to be completed fully for all the shifts. The documentation was to be completed by the PSWs and registered staff, and the completed document was to be provided to the physician for their review.

Inspector #642 interviewed DOC #138, who stated that the identified document was only to be completed on paper, and was required to be completed on all shifts. DOC #138 confirmed that if the identified document was initiated, it was to be fully completed, and it was not completed in its entirety for resident #027. [s. 53. (4) (c)]

4. A CIS report was submitted to the Director on an identified date, in which there was alleged sexual abuse, involving resident #015 towards resident #019.

Inspector #642 reviewed resident #015's paper medical file binder, and identified missing documentation on the identified document:
-Dated: a seven day observation the identified document had been initiated, and there was documentation missing for the following:
-the first date, for a period of eight hours;
-the second date, for a period of seven hours;
-the third date, for a period of an hour;
-the fourth date, for a period of 10 hours.

-Dated: another seven day observation DOS charting was completed for resident #015 and documentation was missing for the following:
-the first date, for a period of three and a half hours;
-the second date, for a period of 11 hours;
-the third date, for a period of 16 hours;
-the fourth date, for a period of four hours.
-Dated: another seven day observation DOS charting was completed for resident #015 and documentation was missing for the following:
-the first date, for a period of 16 hours;
-the second date, for a period of 10 hours;
-the third and fourth date, for a period of 11 hours; and,
-the fifth date, for a period of 16 hours.

In separate interviews with Inspector #642, PSW #108, and #112, identified that PSWs were required to do the identified document when initiated. PSW #120, and RPN #134, also identified that when the identified document was started for residents it was a requirement that the documentation was to be completed fully for all the shifts, by the PSW's and Nurse, and the completed document was to be provided to the physician for their review.

Inspector #642 interviewed DOC #138, who stated that the identified document was only completed on paper and was required to be completed on all shifts, and that if the identified document was initiated it was to be fully completed, and that it had not been for resident #015. [s. 53. (4) (c)]

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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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's substitute decision maker (SDM), if any, and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A CIS report was submitted to the Director on an identified date for an incident that caused an injury to resident #008, that took place three days prior. The CIS report further indicated that on on an identified date, assessment results showed that the resident had an identified injury.

A review of the progress notes by Inspector #736, indicated that on an identified date, staff attended to resident #008, after they were found on the floor in an identified area of the unit. At that time, the resident complained of pain to a specific area of their body. The progress notes indicated that the resident's SDM was notified of the fall the day after the fall.

A review of the home's internal investigate notes, indicated that the SDM was upset that they were not immediately notified of the resident's fall, and that another family member had been made aware of the fall, while visiting the resident the day after the fall. The internal investigation notes further indicated that the RN on shift the day following the fall, notified the family of the resident's fall, when they realized it had not yet been done.

During an interview with CM #152, they indicated to Inspector #736 that when a resident had experienced a fall, the SDM of the resident was to be contacted immediately. The CM indicated that for resident #008, the SDM had not been notified immediately of the fall. CM #152 further indicated that as a result of the SDM not being notified immediately of resident #008's fall, the SDM was not able to participate in the resident's care. The CM explained to the Inspector that the home had changed their practice since the incident, to ensure that all SDMs were notified immediately, regardless of the time a resident sustains a fall. [s. 6. (5)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A CIS report was submitted to the Director on an identified date, related to resident #020 who had gone missing from the home for more than three hours.

Inspector #681 reviewed resident #020's current plan of care, which indicated the following:
- if resident #020 does not complete a specific action by an identified time frame, staff were to initiate specified interventions.
- resident #020 was known to visit a specific location and if they did not return to the home by an identified time, staff were to initiate specified interventions.

The Inspector reviewed resident #020's paper chart, and identified a physician order dated with an identified date, which indicated that the resident was able to go on a Leave of Absence (LOA) until an identified time, daily.

During an interview with Inspector #681, CM #152 stated that the interventions identified in resident #020's care plan no longer applied. The CM stated that if resident #020 was not back on the unit by the identified time, staff were to initiate specified interventions, regardless of where they were going. CM #152 stated that this intervention was based on the physician order that was written by Physician #155 on an identified date. [s. 6. (10) (b)]

3. A CIS report was submitted to the Director on an identified date, related to resident #001 who had gone missing from the home for more than three hours.

Inspector #681 reviewed resident #001's current plan of care, which indicated the

following:
- if resident #001 does not complete a specified action, staff were to initiate a specified intervention after an identified time, and contact the authorities.
- if resident #001 does complete a specified action, but does not return until after an identified time, staff were to initiate a specified intervention after an identified time, and contact the authorities.

The Inspector reviewed resident #001's paper chart and identified a physician order dated with an identified date, which indicated "[LOA], as required until [an identified time]", and complete specified interventions.

During an interview with CM #152, they stated that resident #001 was allowed to go out on a LOA until an identified time, and that this was based on the physician order that had been written by Physician #155. CM #152 stated that resident #001's care plan needed to be updated to reflect that the resident could go out on a LOA until the identified time, regardless of whether the resident completed the specified action. [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 the substitute decision maker is given an opportunity to participate in the development and implementation of the resident's written care plan, and the plan of care is reviewed and revised when the resident's care needs change or the care is no longer necessary, to be implemented voluntarily.

WN #4: 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 the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home submitted a CIS report to the Director on an identified date, which indicated that resident #003 had exhibited an identified responsive behaviour towards resident #002, the previous day. The CIS report indicated that resident #002 had exhibited an identified responsive behaviour towards resident #003, resulting in an injury to resident #003. The CIS report also indicated that RPN #122 intervened, and redirected resident #002 in another location. A further review of the CIS report, indicated that after reviewing the video footage of the incident, it identified that RPN #122 did not separate the residents adequately when the conflict began. The report indicated that by RPN #122 not intervening and redirecting the residents at that time, lead to the incident occurring.

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

Inspector #744 reviewed the home's policy titled, "Extendicare-Zero Tolerance of Resident Abuse and Neglect Program - RC-02-01-01", last revised April 2017, which indicated that there was zero tolerance for abuse and neglect and any form of abuse or neglect by any person, whether through deliberate acts or negligence, would not be tolerated.

Inspector #744 interviewed RPN #122, who identified that they were administering medications to residents at the time of the incident. RPN #122 indicated that they observed resident #022 who appeared to be "irritated", and was approaching resident #003. They indicated that they may have had their back turned away from the residents, and did not intervene when they observed resident #002 approaching resident #003.

During an interview with the CM #132, they confirmed that based on the home's investigation, RPN #122 initially intervened when resident #002 and #003 engaged in conflict; however, they walked away without separating the residents. In a discussion with CM#132, RPN #122 agreed that they could have neglected the resident, because they were busy with other tasks. [s. 20. (1)]

2. A CIS report was submitted to the Director related to an allegation of staff to resident neglect, that occurred on an identified date. The CIS report indicated that resident #004 had not received any nourishment for over an eight hour period. The CIS report also indicated that the resident was found by afternoon staff to be incontinent of bowel and urine, and hygiene care had not been completed for resident #004.

Inspector #681 reviewed resident #004's care plan, that was in place at the time of the incident, which indicated that resident #004 required the extensive assistance of staff for eating, continence care, and dressing. The sleep and rest foci of resident #004's care plan also indicated that the resident woke at an identified time in the morning.

The Inspector reviewed resident #004's dietary report for the day of the incident, which indicated that the resident was marked as "sleeping" for all meals and snacks for an eight hour period.

During an interview with PSW #147, they reported that they worked on the day of the incident. PSW #147 stated that when they went to provide care to resident #004, the resident was still wearing their pajamas, and their incontinence product was very wet and had stool in it. PSW #147 also stated that the resident's clothes were still on the bed side table. PSW #147 stated that resident #004 would usually be up between identified times of the day.

During an interview with PSW #164, they stated that they had also worked on the date of the incident, and had assisted resident #004 with one of their meals. PSW #164 stated that resident #004 was very hungry and thirsty when they assisted them, as the resident had consumed two portions of food and three servings of fluid at the meal.

The Inspector reviewed the home's investigation notes related to the incident, which indicated that video footage was reviewed from the day of the incident. The review of the video footage identified that resident #004 received care from two PSWs at an identified time, but no other PSW went into the resident's room during the identified shift. The home's investigation notes also indicated that it had not been reported that resident #004 had not had nourishment offered to them for an identified time frame.

The Inspector reviewed a document, addressed to PSW #172, dated with an identified date. The document indicated that it was determined through the investigation that on the identified date, PSW #172 was the primary care provider for resident #004, and that they did not provide the resident with their meals and nourishment, and that they should have.

During an interview with Inspector #681, DOC #138 stated that, through the home's investigation, they did not believe that the allegation of neglect had been substantiated. DOC #138 stated that the concern was that PSW #172 was negligent in reporting to RPN #173 that resident #004 had not consumed any food or fluids for the identified time period. DOC #138 did acknowledge that, based on the home's review of the video footage and staff interviews, resident #004 received continence care at an identified time. However, the resident did not receive care again until an identified time, and that the expectation would be for PSW #172 to have gone back to provide resident #004 the care they required. [s. 20. (1)]

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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents and that the policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report was submitted to the Director on an identified date, related to a fall with injury. The CIS report indicated that resident #008 had been heard calling out from an identified area of the home, and was found on the floor in a specific location.

Please see WN #3, finding #1, for further details.

Inspector #736 reviewed resident #008's electronic health record, which indicated that on an identified date, the resident was found on the floor after sustaining a fall. Progress notes further indicated that the fall was not witnessed, and that specific monitoring was to be initiated, which was documented on the monitoring record.

A review of the policy titled, "Falls Prevention and Management Program, RC-15-01-01", last updated February 2017, indicated that if a resident had sustained a fall and had either hit their head, or was suspected of hitting their head (eg., unwitnessed fall), staff were to complete the monitoring record, Appendix 10.

The Inspector reviewed the monitoring record from an identified date, and noted there to be missing monitoring on the record. Of the four checks for an identified time interval one space on the monitoring record indicated "sleeping"; and, of the 10 checks to be completed for another identified time interval, a total of two indicated "sleeping".

In separate interviews with RPNs #126, #137, #153, and RN #143 they indicated to the Inspector that the monitoring record was to be initiated when a resident had an unwitnessed fall, or when a resident had fallen and was seen to have hit an identified area of their body. They all further indicated that if a resident was sleeping during a time when the specific monitoring was to be completed, the expectation was to wake the resident, and complete the checks. Together, Inspector #736 and RPN #126, reviewed the monitoring record for resident #008, that was started on an identified date. The RPN confirmed to the Inspector that the monitoring record was not filled out in its entirely, and should have been. The RPN further confirmed that the care that was set out in the plan of care was not documented for resident #008 related to their fall on the identified date.

In separate interviews with Inspector #736, CM #152 and DOC #138, both indicated to Inspector #736 that the monitoring record was to be initiated if a resident had an unwitnessed fall, or if the resident had sustained a fall and was seen to have hit an identified area of their body. Both the CM and DOC further indicated separately, that staff were to wake the resident if they were sleeping during a time when they were to have to

monitoring record completed. The Inspector reviewed the monitoring record for resident #008 after their fall on the identified date, with both CM #152 and DOC #138 separately. Both the DOC and CM, indicated that the care was not documented as set out in the plan of care for resident #008 after their fall on the identified date, and that it should have been. [s. 49. (2)]

2. A CIS report was submitted to the Director on an identified date, related to a fall with injury. The CIS report indicated that resident #009 had an unwitnessed fall four days prior.

Inspector #736 reviewed resident #009's electronic health record, which indicated that on an identified date, the resident was found in an identified area of the unit. Progress notes further indicated that the fall was not witnessed, and the resident was started on specific monitoring, which was to be documented on the monitoring record.

The Inspector reviewed the monitoring record for an identified date, and noted there to be missing monitoring on the record. Of the four checks for an identified time interval, two spaces indicated "sleeping" and the last check that should have been completed an identified time, was not written on the sheet. Of the 10 checks to be completed every eight hours another time interval, a total of two sleeping, and two were blank.

Together, the Inspector and RPN #137 reviewed the monitoring record for resident #009 that was started on an identified date. The RPN confirmed to the Inspector that the monitoring record was not filled out in its entirely, and should have been. The RPN further confirmed that the care that was set out in the plan of care was not documented for resident #009, related to their fall on the identified date

In separate interviews with CM #152 and DOC #138, they indicated to Inspector #736 that the monitoring record was to be initiated if a resident had an unwitnessed fall, or if the resident had sustained a fall and was seen to have hit an identified area of their body. Both the CM and DOC further indicated separately, that staff were to wake the resident if they were sleeping during a time when they were to have a monitoring record completed. The Inspector reviewed the monitoring record for resident #009 after their fall on the identified date, with both the CM and the DOC separately. Both DOC #138 and CM #152, indicated that the care was not documented as set out in the plan of care for resident #009 after their fall on the identified date. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #6: 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 :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with O.Reg. 49(1), the licensee was required to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's Falls Management policy, LTC 3-60, which is part of the licensee's Falls Prevention program.

A CIS report was submitted to the Director related to resident #008 having sustained a fall with a significant injury. The CIS report indicated that the resident fell on an identified

date, and five days following the fall, it was determined that the resident had sustained an injury.

Please see WN #3, finding #1 and WN #5, finding #1, for further details.

Inspector #736 reviewed resident #008's electronic health care record, which indicated that the resident had fallen on an identified date. Physician #155 confirmed, to the home that the resident had sustained an identified injury.

The Extendicare Falls Prevention and Management Program, LTC 3-60, last reviewed February 2017, and adopted by Hogarth Riverview Manor December 18, 2017, indicated that all residents were to be screened on admission, annually, with a change in condition that could potentially increase the resident's risk of falls/fall injury, or after a serious fall injury or multiple falls (if not already at high risk), by using the Scott Falls Risk Screen.

Inspector #736 further reviewed resident #008's electronic health care records and located an identified assessment tool, dated on an identified date. The identified assessment tool indicated that the resident required specific interventions for fall prevention. The Inspector could not locate any identified assessment tool completed for resident #008 after their fall on the identified date.

In an interview with RN #143, they indicated to Inspector #736 that an identified assessment tool was to be completed on admission for every resident on the electronic documentation system, and completed again after a resident had fallen. The RN reviewed resident #008's progress notes, and confirmed that the resident had fallen, sustaining an injury. Together, the Inspector and RN#143 reviewed the resident's assessments on the electronic documentation system. The RN was unable to locate evidence of a completed identified assessment tool after the resident sustained a fall on the identified date. The RN indicated that the resident should have had an identified assessment tool completed after they sustained a fall, resulting in injury.

In an interview with DOC #138, they indicated to the Inspector that the policy required a new identified assessment tool was to be completed for a resident after they had sustained an injury. The DOC confirmed that resident #008 had sustained an injury when they fell on the identified date. Together, the DOC and Inspector #736 reviewed the resident's clinical health care records, and the DOC could not locate an identified assessment tool that was completed after the resident had fallen on the identified date. The DOC indicated that the staff should have completed an identified assessment tool for

resident #008 after their fall, and because they had not, the home's Falls policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in respect to each of the interdisciplinary programs required under section 48 of this regulation, the program must have been evaluated and updated at least annually, and a written record kept that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made, and the date those changes were implemented.

Inspector #736 requested the program evaluation for the Falls Prevention program, and was provided with a completed audit dated with an identified date. The audit did not include the names of the persons who participated in the evaluation, a summary of the changes made, and the date those changes implemented.

In an interview with the Administrator, they indicated to Inspector #736, that DOC #138 and the multidisciplinary team were responsible to complete the annual program evaluation for the Falls Prevention program. The Administrator indicated that the written review of the annual evaluation was to include the names of those who participated in the evaluation, the date of the evaluation, a summary of changes made and the dates those changes were implemented. The Administrator indicated to the Inspector that the annual evaluation for the Falls Program did not contain the required information and should have. [s. 30. (1) 4.]

2. Inspector #736 requested the program evaluation for the Responsive Behaviours program, and was provided with a completed audit dated with an identified date. The audit did not include a summary of the changes made and, the date those changes were implemented.

In an interview with the Administrator, they indicated to the Inspector #736, that DOC #138 and the multidisciplinary team were responsible to complete the annual program evaluation for the Responsive Behaviour program. The Administrator indicated that the written review of the annual evaluation was to include a summary of the changes made and the date those changes were implemented. The Administrator indicated to the Inspector that the annual evaluation for the Responsive Behaviours program contained the list of those that participated in the evaluation, but did not contain the rest of the required information and should have. [s. 30. (1) 4.]

Issued on this 22nd day of August, 2019

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

Original report signed by the inspector.

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

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) :	SHANNON RUSSELL (692), AMANDA BELANGER (736), AMY GEAUVREAU (642), STEPHANIE DONI (681), STEVEN NACCARATO (744)
Inspection No. / No de l'inspection :	2019_746692_0019
Log No. / No de registre :	022982-18, 005445-19, 005611-19, 006107-19, 007163-19, 007197-19, 007998-19, 008966-19, 009435-19, 009886-19, 010707-19, 011247-19, 011308-19, 011508-19, 011748-19, 011813-19, 012052-19, 012587-19, 012847-19, 013191-19, 013206-19, 014491-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 20, 2019
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Hogarth Riverview Manor 300 Lillie Street, THUNDER BAY, ON, P7C-4Y7

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

Name of Administrator / Nom de l’administratrice ou de l’administrateur : Sheila Clark

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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(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 : 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. 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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be in compliance with s. 19 (1) of the LTCHA.

Specifically, the licensee must:

a) Protect residents #030 and #019, and all other residents from sexual abuse from resident #015;
b) Reassess resident #015's behaviours and implement strategies to prevent further incidents of resident to resident sexual abuse; and
c) Ensure that all staff responsible for the care of resident #015 are aware of resident #015's sexually inappropriate behaviours and the interventions that are in place to prevent sexual abuse towards others, especially the responsibilities of the identified intervention.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Sexual abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

a) A Critical Incident System (CIS) report was submitted to the Director, on an identified date, as Personal Support Worker (PSW) #135 had reported an alleged sexual abuse involving resident #015 towards resident #019, who stated that resident #015 had exhibited a responsive behaviour of a sexual nature towards them in an identified area of the unit.

Inspector #642 reviewed resident #019's electronic progress notes on Med-e-care, and identified three progress notes, documented by three different nurses, Registered Practical Nurse (RPN) #134, Registered Nurse (RN) #140 and #141. They had documented that resident #015 had been in an identified area of the unit, when resident #019 had identified resident #015 as the one who had exhibited a responsive behaviour of a sexual nature towards them, and that they had been upset about it, and wanted the authorities notified.

Inspector #642 reviewed resident #015's care plan, in effect at the time of the incident, and under an identified focus, resident #015 had a history of exhibiting responsive behaviours of a sexual nature towards others, and was identified as requiring an identified intervention at all times.

Inspector #642 reviewed the home's policy titled, "Zero Tolerance of resident Abuse and Neglect Program," last revised on April 2017. The policy defined sexual abuse as, "any non-consensual touching, behaviour, or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

Inspector #642 interviewed the PSW #130, who completed the identified intervention for resident #015, on the identified date. The PSW stated resident #015 had requested the PSW complete an action for them. and that PSW #130 thought it would be safe, so they ceased the identified intervention. The PSW stated that when they went to commence the identified intervention again, resident #015 was no longer in the location that they had been in, and they had to go look for them. PSW #130 stated they had found resident #015 in an area of the unit in the close proximity of resident #019, and that resident #019 was really upset. The PSW stated they had not seen what resident #015 was doing, since they could only see their back side. PSW #130 stated that they re-directed the resident to a different location, and resident #019 was upset.

Inspector #642 separately interviewed PSW #135, and #151, who were proving resident care together for resident #019, when resident #019 stated, that another resident had exhibited a responsive behaviour of a sexual nature towards them. The PSW's stated that at first they were not sure what had happened, or who had exhibited the responsive behaviour towards resident

#019. They had informed the nurse at that time of what they had been told by resident #019.

Inspector #642 had interviewed RPN #134, who had documented the first progress note about the incident, and they stated they had informed CM #166, who stated they would review the units video footage.

The Inspector had reviewed the home's investigation notes, and reviewed the description of the video footage documented by Clinical Manager (CM) #166, which chronologically described when the identified intervention was stopped, and the location that resident #015 had gone.

When Inspector #642 interviewed PSW #151, they stated that when they were assisting resident #019 on the unit, they had pointed to resident #015 as the resident that exhibited a responsive behaviour of a sexual nature towards them, and they wanted the authorities contacted. PSW #151 stated that they were also with resident #019 when they told the authorities of the events that had taken place.

Inspector interviewed the Resident Assessment Instrument Coordinator (RAI-C) #167, who identified in resident #015's care plan, under an identified focus that resident #015 was to have an identified intervention at all times.

b) A CIS report was submitted to the Director on an identified date, which alleged a sexual abuse incident involving resident #015, whereby they exhibited a responsive behaviour of a sexual nature towards resident #030.

Inspector #642 reviewed the Med-e-care electronic progress notes, for an identified date, for resident #030, and identified in the notes that resident #015 had exhibited a responsive behaviour of a sexual nature towards resident #030 during a recreational activity at a public area of the home, and the resident had been very upset. Resident #030 quickly intervened to stop the responsive behaviour, and walked away from the area. The primary nurse assessed resident #030, and they stated they were very "furious" about the incident.

The Inspector reviewed the home's investigation notes, and when resident #030 was interviewed on the date of the incident, resident #030, stated they were

angry, taken off guard, and no longer felt safe in the home.

Inspector #642 interviewed resident #030, who stated that they sat down in the public area of the home, sitting by resident #015. They stated that the incident happened so fast, and that they do not feel safe in the home at this time, and they were still visibly upset about the incident.

Inspector #642 interviewed Therapeutic Recreationist (TR) #160, who had been in the area at the time of the incident, and had assisted resident #030 after the incident occurred. The TR stated they had been sitting behind residents #015 and #030, when suddenly they observed resident #030 leave the area, appeared upset. TR #160 stated that resident #030 told them, that resident #015 had exhibited a responsive behaviour of a sexual nature towards them, when they assisted resident #030 back to their room. TR #160 stated that the resident had an identified intervention in place for previous incidents of responsive behaviour of a sexual nature towards others, but they were not completing the identified intervention at the time of the incident.

Inspector #642 interviewed PSW #120, who had been providing the identified intervention for resident #015 on the identified date. PSW #120, stated they had not seen the incident between resident #015 and resident #030, because they were in an area that they were unable to observe the residents. The PSW had seen resident #030 "storm off", and asked TR #160 what had happened, and at that time it was reported that resident #015 had exhibited a responsive behaviour of a sexual nature towards resident #030.

Inspector #642 interviewed the Administrator, who stated that identified intervention should have been completed for resident #015, at all times. When the identified intervention was to be in place at all times, in order to keep other residents safe, and they did not do that.

The severity of this issue was determined to be a level three, as there was actual harm/actual risk. The scope of the issue was a level two, as the incident of resident to resident abuse was a pattern. The home has a level three compliance history with related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10.
-Voluntary Plan of Correction (VPC) issued June 4, (2019, 2019_633577_0010);

-Written Notice (WN) issued February 12, 2019, (2019_768693_0002);
-Director Referral (DR) issued October 11, 2018, (2018_624196_0024);
-WN issued May 24, 2018, (2018_633577_0006);
-Compliance Order (CO) issued March 22, 2018, (2018_655679_0005);
-WN issued February 2, 2018, (2018_657681_0020);
-WN issued October 11, 2017, (2017_509617_0017); and,
-CO issued November 1, 2016, (2019_391603_0024). (642)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2019

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must be compliant with s. 53 (4).

Specifically, the licensee must:

a) Develop and implement a process to ensure that staff are completing an identified document, as per the home's policies and procedures.
b) Develop and conduct audits to ensure that the identified document is being completed as required, and maintain a record of the audits that are conducted.

Grounds / Motifs :

1. A CIS report was submitted to the Director on an identified date, in which there was an allegation of physical abuse, involving resident #027 towards resident # 028, resulting in a fall of resident #028.

Inspector #642 identified under the Physicians order for resident #027, on the date of the incident, a physician order, which indicated for staff to initiate the identified document.

The Inspector also observed in the electronic medical notes, in Med-e-care, on an identified date, a progress note, which stated, the identified document was initiated, documented by RPN #114.

Inspector #642 reviewed resident #027's paper medical file binder and identified missing documentation on the identified document:
-Dated: a seven day observation when the identified document had been initiated, and there was documentation missing for the following:
-the first date, for a period of eight hours;
-the second and third dates, for a period of an hour;
-the fourth date, for a period of eight hours;
-the fifth date, for a period of 16 hours.
-Dated: another seven day observation when the identified document was completed for resident #027 and documentation was missing for the following:
-the first date, for a period of 14 hours;
-the second date, for a period of eight hours;
-the third, fourth and fifth dates, for a period of 15 hours; and,
-the sixth and seventh dates, the entire day was missing;

Inspector #642 interviewed PSW #108, and #112, who identified that PSWs were required to complete the identified document when initiated. PSW #120, and RPN #134, also identified that when the identified document was started for residents, it was a requirement that the documentation was to be completed fully for all the shifts. The documentation was to be completed by the PSWs and registered staff, and the completed document was to be provided to the physician for their review.

Inspector #642 interviewed DOC #138, who stated that the identified document was only to be completed on paper, and was required to be completed on all shifts. DOC #138 confirmed that if the identified document was initiated, it was to be fully completed, and it was not completed in its entirety for resident #027. [s. 53. (4) (c)]
(692)

2. A CIS report was submitted to the Director on an identified date, in which there was alleged sexual abuse, involving resident #015 towards resident #019.

Inspector #642 reviewed resident #015's paper medical file binder, and identified missing documentation on the identified document:
-Dated: a seven day observation the identified document had been initiated, and there was documentation missing for the following:

-the first date, for a period of eight hours;
-the second date, for a period of seven hours;
-the third date, for a period of an hour;
-the fourth date, for a period of 10 hours.
-Dated: another seven day observation DOS charting was completed for resident #015 and documentation was missing for the following:
-the first date, for a period of three and a half hours;
-the second date, for a period of 11 hours;
-the third date, for a period of 16 hours;
-the fourth date, for a period of four hours.
-Dated: another seven day observation DOS charting was completed for resident #015 and documentation was missing for the following:
-the first date, for a period of 16 hours;
-the second date, for a period of 10 hours;
-the third and fourth date, for a period of 11 hours; and,
-the fifth date, for a period of 16 hours.

In separate interviews with Inspector #642, PSW #108, and #112, identified that PSWs were required to do the identified document when initiated. PSW #120, and RPN #134, also identified that when the identified document was started for residents it was a requirement that the documentation was to be completed fully for all the shifts, by the PSW's and Nurse, and the completed document was to be provided to the physician for their review.

Inspector #642 interviewed DOC #138, who stated that the identified document was only completed on paper and was required to be completed on all shifts, and that if the identified document was initiated it was to be fully completed, and that it had not been for resident #015. [s. 53. (4) (c)] (692)

3. The licensee has failed to ensure that, for each resident that demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions were documented.

A CIS report was submitted to the Director related to a fall with injury on an identified date. The CIS report indicated that resident #025 had returned from a Leave of Absence (LOA), and began to exhibit an identified responsive

behaviour. The resident sustained a fall, when they began to exhibit the identified responsive behaviour.

A review of resident #025's electronic health care records by Inspector #736, identified a progress note, dated with an identified date, documented by RN #142, that indicated that staff were to complete an identified document for resident #025. A further review of the resident's records, by the Inspector, identified a physician's order, dated with an identified date, that indicated that the resident was to have the identified document completed for seven days. The Inspector located the DOS document for resident #025, for a 14 day period, in the resident's paper chart. Of the 14 days on the sheet, nine of the 24-hour time periods were blank, and had no documentation. Of the other five days, the following entries were blank:
-the first date, for a period of 14 hours;
-the second date, for a period of 16 hours;
-the third and fourth dates, for a period of 8 hours; and,
-the fifth date, for a period of 16 hours.

In an interview with RN #143, they indicated to Inspector #736, that the identified document would be initiated for a resident at times as a nursing measure to determine patterns for a resident with responsive behaviours. The RN further indicated that at times the physician would order the staff to complete the identified document for a resident if they were demonstrating responsive behaviours. The RN indicated to the Inspector that the identified document was considered to be part of the resident's plan of care, and once initiated it was to be completed in its entirely, with no blank spaces. Together, RN#143 and the Inspector, reviewed the physician's order for resident #025, which described that the resident was to have had the identified document initiated. Then, together, the RN and Inspector, reviewed the identified documents for resident #025 for a 14 day period. RN #143 confirmed that care had not been documented, as set out in the plan of care.

In separate interviews with Inspector #736, CM #152 and Director of Care (DOC) #138, indicated that the identified document would be initiated for residents who displayed responsive behaviours as either a nursing measure, or as a physician's order. The CM and the DOC both, indicated that the identified document should have been filled out in its entirety, Together, both the CM and

the DOC, reviewed the identified documents with the Inspector for resident #025 for the selected 14 day period, and indicated that the identified document was not filled out in its entirety. The CM and the DOC both indicated that the care for resident #025 was not documented as set out in the plan of care related to the identified document, and it should have been. [s. 53. (4) (c)] (736)

4. The home submitted a CIS report to the Director, which indicated that resident #006 had exhibited a responsive behaviour towards resident #010. The CIS report further indicated that when resident #006 exhibited the responsive behaviour towards resident #010, they sustained an injury.

Inspector #744 reviewed the physician's orders, dated with an identified date, for residents #006 and #010, which instructed nursing staff to complete the identified document for two weeks, as a result of the incident.

Inspector #744 reviewed the identified document initiated on an identified date, and found the following missing documentation for residents #006 and #010:
-for three consecutive days - no documentation for a five hour period; and,
-No documentation for week two observations.

During an interview with PSW #148, the identified document was reviewed together with Inspector #744. PSW #148 indicated that they were working on the shifts when the documentation was missing. They further indicated that normally "[it was] a team effort" to have the identified document completed for the identified time intervals, and it may have been forgotten.

During an interview with RPN #134, they indicated to Inspector #736 that the need for the identified document for each resident was to be communicated to staff during the RPN shift report. If the PSWs did not complete the identified document, then RPNs would ensure it was completed. RPN #134 also indicated that they believed that the missing documentation for residents #006 and #010 was because staff had forgotten to document.

In an interview with CM #149, they indicated that they could not locate the missing documentation the identified document, and was not aware of any reason why there was inconsistent documentation. CM #149 confirmed that the identified document had not been fully completed for the specified time intervals

for residents #006 and #010, as per their expectation. [s. 53. (4) (c)]

The severity of this issue was determined to be a level two, as there was minimal harm/minimal risk. The scope of the issue was a level three, as the DOS charting that was not completed was widespread. The home had a level three compliance history with related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10.
-Written Notice (WN) issued February 12, (2019, 2019_768693_0002); and,
-Voluntary Plan of Correction (VPC) issued November 7, (2016, 2016_391603_0022). (744)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 14, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 20th day of August, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shannon Russell

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