Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jun 9, 2020	2020_633577_0008	024185-19, 000861-20, 001185-20, 001962-20, 001965-20, 002546-20, 002553-20	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

DEBBIE WARPULA (577), CHAD CAMPS (609), JULIE KUORIKOSKI (621)

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): May 19 to 22 and 25 to 28, 2020.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
-Five logs submitted to the Director for allegations of staff to resident neglect; and
-Two logs submitted to the Director for allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Managers (CMs), Interim Resident Engagement Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) Coordinators, residents, their family members.

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, reviewed the home's internal investigation notes, staff education records and reviewed licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right not to be neglected by the licensee or staff.

A Critical Incident System (CIS) report was received by the Director on an identified date, related to staff to resident neglect. The CIS report indicated a complaint was received by the home from resident #005's family member on an identified date. The complaint alleged that resident #005 had not received a particular meal on an identified date, the resident had been left incontinent, and staff had not changed them over a specified time period.

Ontario Regulation 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.

A review of the home's policy, "Zero Tolerance of Abuse and Neglect Program – RC-02-01-01", revised June 2019, indicated that Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. Extendicare had 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.

A review of the home's policy, "Care and Comfort Rounds - RC-12-01-06", revised February 2017, indicated that the home would schedule regular care and comfort rounds at set intervals to proactively anticipate resident needs related to pain, positioning, prompted toileting, proximity to personal items and other comfort and safety issues; the policy further indicated that comfort rounds were scheduled every two hours.

A review of the home's investigation notes indicated the following:
-an interview with CM #102 and resident #005's family member indicated that they had called the unit at an identified time and spoke with RPN #124; advised them that they had discovered through a specific apparatus, their family member to have been incontinent and engaged in a specific activity; and requested that the resident be provided with continence interventions;
-an interview with RPN #124 and CM #102 indicated that they had received a phone call from resident #005's family member, advised that the resident was incontinent, was engaged in a specific activity in their room and requested that the resident be provided

with continence interventions; RPN #124 stated that PSW #122 and PSW #123 were directed to have provided continence interventions;
- video footage indicated that PSW #122 exited resident #005's room with an empty dinner tray on an identified date, at an identified time; PSW #122 and PSW #123 entered resident #005's room three hours later to provide continence interventions; and
-an interview with PSW #123 and Clinical Manager (CM) #102 indicated that care had been provided to resident #005 at an identified time; RPN #124 had directed them to provide continence interventions for resident #005 at an identified time; CM #102 advised PSW #123 that it was unacceptable to have left resident #005 soiled for two hours.

A review of a progress note documented by RPN #124, on an identified date, at an identified time, indicated that resident #005 had been incontinent, had been engaged in a specific activity in their room, and the resident's family member had discovered the activity through a specific apparatus and called the nursing unit and advised staff.

During an interview with CM #102, they advised Inspector #577 that a review of video footage from an identified date, revealed that PSW #122 and PSW #123 had not provided resident #005 with continence interventions until an identified time; resident #005's family member had called the nursing unit at an identified time and spoke with RPN #124 and requested that the resident be provided with continence interventions, as they were soiled and engaged in a specific activity; RPN #124 directed PSW #122 and PSW #123 to provide continence interventions; CM #102 advised Inspector #577 that PSW #122 and PSW #123's actions constituted neglect of resident #005, as resident #005 had been left soiled and had not been provided with continence care for two and a half hours. [s. 3. (1) 3.]

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 all residents are not neglected by the licensee or staff, to be implemented voluntarily.

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 :

1. The licensee has failed to ensure that the staff involved in the different aspects of care of resident #006 collaborated with each other, in the implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A CIS report was submitted by the home to the Director on an identified date, which alleged that resident #006 was not changed when PSW #109 found them incontinent in their brief. Please see Written Notification (WN) #3 for further details.

During an interview with Inspector #609, PSW #109 described checking on resident #006 at an identified time on an identified date, to find that they were still in their clothes and incontinent in a specific manner. The PSW indicated that the resident was usually assisted to bed shortly after a specific meal time and that there was no reason their care should not have been completed.

A review of resident #006's plan of care at the time of the incident found that the resident required specific assistance with one to two staff to perform particular care activities and was to be provided specific care after each incontinence episode.

A review of the schedule for a particular shift of an identified date, found that PSW #108 was assigned the care of resident #006.

During an interview with PSW #108, they verified that they were assigned resident

#006's care on a specific shift on an identified date, and was completing care as a team with PSW #110 and #122. The PSW outlined how after their specific break, they checked on resident #006 who was observed in bed and under a blanket. PSW #108 acknowledged that when they observed resident #006, they were still wearing clothes, but had assumed the resident was provided care by another PSW and maybe refused a change of clothes. PSW #108 had documented that all the care was provided and stated that "it was my fault for not checking with [the two other PSWs] to make sure that the care was done".

A review of the home's policy, "Plan of Care - RC-05-01-01", revised June 2019, indicated that the plan of care identified care needs to allow the care team to implement strategies to provide appropriate care.

During an interview with CM #102, they indicated that staff were encouraged to work in teams, but that clear communication was required. If all the PSWs were working together then it was PSW #108's responsibility as the PSW assigned the resident to check that the care was provided and should not have documented that the care was provided unless they were sure. [s. 6. (4) (b)]

2. 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.

A CIS report was received by the Director on a specified date, related to the improper care of resident #004. The report indicated a written complaint received by the home from resident #004's family member on a specified date, which alleged that a particular care activity had not been offered to resident #004 and PSW #125 and a student had provided care when the resident had been displayed specific behaviour on an identified date.

A review of the home's policy, "Plan of Care - RC-05-01-01", revised June 2019, indicated that the care plan served as a communication tool which promoted the safe and effective resident care and provided documentation which identified immediate risks to safety and care needs to allow the care team to implement strategies to mitigate risk and provide appropriate care.

A review of resident #004's care plan in place at the time of the incident, identified that the resident was to have a particular care activity by staff at particular times; staff were to re-approach the resident if they exhibited particular behaviours and return at a later time

and utilize a different staff member if possible.

A review of the home's investigation notes identified a particular letter on a specified date, from CM #126 to PSW #125. The letter indicated that PSW #125 had not followed the care plan in regards to a particular care activity and the required persons to assist. Further, it was the expectation that they review the resident's care plan and follow the interventions accordingly.

During an interview with PSW #125, they advised Inspector #577 that resident #004 had displayed a particular behaviour and they were unable to assist them with a particular care activity; and they provided continence care for the resident in a particular area when they displayed a particular behaviour.

During an interview with CM #126, they advised Inspector #577 that PSW #125 had not followed resident #004's plan of care; specifically, they should have discontinued care when the resident displayed a particular behaviour and re-approached them later [s. 6. (7)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other; and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 homes written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Ontario Regulation (0. 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.

The home submitted a CIS report to the Director on an identified date, which indicated that a written complaint had been received the same day, which alleged that resident #002 had been left in a particular area for an extended period of time following a specific meal, on an identified date.

On further review of the CIS report, it indicated that, on review of video footage, resident #002 had been found seated in a particular area for more than four hrs, and had not been assisted with a particular care activity following two specific meals, as per their plan of care. Additionally, a second resident (resident #001), was also found to be left in a particular area for more than six hrs and had not been checked at specific times for incontinence, as per their plan of care.

Inspector #621 reviewed resident #002’s care plan in place at the time of the incident, which identified under a specific focus, that staff were to assist the resident with a specific care need after two specific meals each day. Additionally, a review of resident #001’s care plan, which was effective on an identified date, under another specific focus, that the resident was to be checked and changed at particular times, and as needed.

A review of the home’s CIS investigation notes, identified that PSW #103 had worked on a particular unit, over a specified time period, on an identified date. An interview with PSW #103 on an identified date, indicated that PSW #103 had been assigned to a

particular board, which included care for resident's #001 and #002, and that PSW #103 admitted to leaving both residents in a particular area. Further PSW #103 was documented stating that they did not recall whether they provided care to resident #001 that shift, and recalled only providing specific care to resident #002. PSW #103 also confirmed that they had not recently reviewed either resident's care plans.

During an interview with with RPN #114, they reported to the Inspector that PSWs were expected to know their resident's care needs, and check the resident's Kardex information at the start of each shift for updates. They reported that they were aware of an incident where PSW #103 had left resident #001 and #002 in a particular area for an extended period of time. RPN #114 identified that resident #001 required to be checked for incontinence at particular times and resident #002 required specific care needs after meals.

A review of the home's adopted policy from Extendicare, "Zero Tolerance of Resident Abuse and Neglect Program, RC-02-02-02", revised June 2019, identified that all residents were to be treated with dignity and respect, and protected from all forms of abuse or neglect at all times.

A review of the home's adopted policy from Extendicare, "Care and Comfort Rounds, RC-12-01-06", revised February 2017, a notation for Appendix 1 (Comfort Rounds Poster) which was documented on the front cover to the policy, identified that "The Director of Care has determined that the frequency of checks will be every one hour".

On review of the corresponding Complaint Investigation, which was completed by the home for this incident, the Inspector noted email correspondence with the Central Intake Assessment and Triage Team (CIATT) on an identified date, indicating that the home was in receipt of the written complaint as of an identified date, but had not forwarded it in a timely fashion.

A review of the home's adopted policy from Extendicare, "Complaints and Customer Service, RC-09-01-04", revised June 2019, indicated that "In Ontario, homes must forward a copy of the written complaint immediately to the Ministry of Health and Long-Term Care".

During an interview with Clinical Manager #101, they confirmed to the Inspector that at time of the incident, PSW #103 was found to have neglected resident's #001 and #002 who were part of their resident assignment on an identified date, and as a result did not

comply with the home's zero tolerance of abuse and neglect policy. Resident neglect was determined as a result of PSW #103 failing to complete hourly checks on resident #001 and #002, as part of care and comfort round policy requirements; failing to complete continence care checks at particular times on resident #001, as per their plan of care; and failing to complete specific care after two particular meals for resident #002, as per their plan of care.

Additionally, Clinical Manager #101 also verified to the Inspector that, the written complaint dated from an identified date, was not forwarded immediately to the Director as per legislative requirements. As a result of the oversight, a copy of the complaint was forwarded late on an identified date. [s. 20. (1)]

2. A CIS report was submitted by the home to the Director on an identified date, which described allegations that resident #006 was neglected when particular care was not provided to them on an identified date. Please see WN #2 for further details.

A review of the home's internal investigation found in an email to CM #102 by PSW #109 on an identified date, detailed a description of finding resident #006 at a particular time in their clothes and brief which were incontinent of bowel movement. There was a strong smell of urine and was saturated through to the sheets.

During an interview with PSW #109, they indicated that upon finding resident #006 apparently neglected, they did not immediately report the neglect to registered staff. Instead, they cleaned up the resident, erasing all evidence of the potential neglect or abuse. The PSW indicated that they later "mentioned" the neglect to the RPN yet could not remember who the RPN they mentioned the neglect to was.

A review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", revised June 2019, required staff who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect would report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time. The Supervisor would be responsible for ensuring completion of the CIS report.

A review of an interview with one of the RPNs at the time of the incident (#107), as part of the home's internal investigation on an identified date, found that they denied any knowledge of the potential neglect of any resident.

During an interview with the second RPN at the time of the incident (#120), they verified that they were working a particular shift on an identified shift, and denied being notified of any potential neglect of resident #006 or any other resident that shift. The RPN indicated that had they been made aware of any allegations of potential abuse or neglect of a resident, they would have immediately reported it to the RN who would have immediately notified their manager.

During an interview with CM #102, a review of the CIS was conducted. They indicated that if a PSW identified allegations of abuse or neglect of a resident, then they should have immediately notified the RPN, as the on call manager would have to be notified. The CM described however, receiving an email when they arrived to the home on an identified date, from PSW #109 which outlined the allegations of neglect of resident #006 on an identified date. This resulted in a 1.5-day delay in the CIS report to the Director. [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 the homes written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

O. Reg. 79/10 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A CIS report was submitted by the home to the Director on an identified date, which described allegations of verbal abuse of resident #007 by PSW #111 that occurred during a particular time on an identified date. The report further described how RPN #112 was informed of the allegations by resident #008 who had overheard the incident.

During an interview with RPN #112, they outlined to Inspector #609, how resident #008 informed them on an identified date, at an identified time, that they had overheard PSW #111 speak loudly to resident #007 and refuse to take the resident to a particular area to assist with a particular care need. Resident #008 informed the RPN that PSWs should not speak to residents like that. RPN #112 indicated that they immediately checked on resident #007 and reported the allegations to RN #121.

During an interview with RN #121, they described being notified by RPN #112 of the allegations of abuse of resident #007 by PSW #111 at an identified time on an identified date. The RN indicated that they then called and informed on-call manager CM #119 of the allegations as well as forwarded an email to CM #102 which also outlined the allegations of abuse.

During an interview with CM #119, they indicated that RN #121 had informed them of the allegations of abuse, but felt the comments were made in “jest” and not a critical incident.

A review of the email sent by RN #121 to CM #119 on an identified date, at an identified time described allegations that PSW #111 was overheard speaking in a very loud tone and refusing to provide care to resident #007.

A review of the home’s policy, “Zero Tolerance of Resident Abuse and Neglect: Response and Reporting”, revised June 2019, indicated that management would promptly and objectively report all incidents to external regulatory authorities as well as complete the CIS report.

During an interview with CM #102, they verified that the allegations of abuse of resident #007 were reported late to the Director, after RN #121 had informed CM #119 on an identified date. The CM described how the email from RN #121 on an identified date, contained allegations of abuse which were not immediately reported to the Director until the email was reviewed by the management team on an identified date. This resulted in the CIS being reported approximately 2.5 days after CM #119 was aware of the allegations of abuse. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal or written complaint made to the licensee or a staff member concerning the care of a resident was investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint.

A CIS report was received by the Director on an identified date, related to staff to resident neglect. The CIS report indicated a complaint was received by the home from resident #005's family member on an identified date. The complaint alleged that resident #005 had not received a particular meal on an identified date, had been left incontinent, and staff had not changed them for nearly two hrs.

A review of the home's policy, "Complaints and Customer Service, RC-09-01-04", revised June 2019, indicated that the Administrator was to have initiated an investigation into the circumstances leading to the complaint within 24 hours; an investigation was to be completed within ten days, and if not within ten days, the complainant was to be contacted to have been informed that the investigation was ongoing and provided an estimated date of completion of the investigation; as well as to have provided the complainant with regular updates on the process until the investigation was completed. The policy also indicated that once the investigation was concluded, the Administrator was to have provided a written response to the complainant that would have included what the home did to resolve the complaint, and if the complaint was unfounded, the reasons why this conclusion was reached.

Inspector #577 reviewed the complaint response letter from CM #102 to resident #005's family member, on an identified date, sent via email. The letter indicated that their concerns were reported to the Ministry of Long-Term Care and an investigation was conducted. As a result of the investigation, the staff had been reminded to have completed frequent checks and to follow-up in a timely manner when an issue was identified.

During an interview with CM #102, they advised Inspector #577 that they had followed up with resident #005's family member on an identified date, and discussed the results of the investigation. They further advised that the written response letter was not sent within ten business days. [s. 101. (1) 3.]

Issued on this 10th day of June, 2020

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

Original report signed by the inspector.