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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 28, 2020	2020_768693_0012 (A1)	004599-20, 005139-20, 005906-20, 007611-20, 010353-20, 013183-20	Complaint

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

Amended by MELISSA HAMILTON (693) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Issued on this 28th day of September, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by MELISSA HAMILTON (693) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 6 to 10, 13 to 17, and 20 to 24, 2020.

The following intakes were inspected upon during this Complaint inspection:

-one intake, regarding alleged staff to resident abuse;

-two intakes, regarding long term care home complaint and response letters;

-one intake, regarding infection prevention and control;

-one intake, regarding staffing; and

-one intake, regarding resident care concerns.

Critical Incident System (CIS) inspections #2020_768693_0013, and #2020_768693_0014, and Follow Up inspection #2020_768693_0011 were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers (CM), Registered Nurses (RNs), Resident Assessment Instrument Coordinators (RAI Coordinators), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, Resident Home Workers (RHW), residents, and their family members.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

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

The home submitted a record of a verbal complaint, to the Director, on an identified date, as well as the home's response to the complainant on another identified date. The record of verbal complaint indicated that the Substitute Decision Maker (SDM), for resident #037, had made a verbal complaint to the Administrator, on an identified date. The complainant indicated that resident #037 had developed a area of impaired skin integrity, and treatment was not timely, subsequently the area of impaired skin integrity became infected and progressed. The complainant further indicated that the resident had been referred to an Occupational Therapist (OT), and was not seen in a timely manner, and in addition that the resident had an overall decline in condition, and the staff did not educate the family that this decline may have been a result of the area of impaired skin integrity and increased pain. Lastly that the resident had increased pain, and the pain was not managed.

During an Interview with CM #100, they acknowledged that the complaint made on an identified date, from resident #037's SDM, was regarding alleged improper and incompetent care, and that a Critical Incident System (CIS) report should

have been immediately submitted to the Director, for this allegation, but was not.

Inspector #693 reviewed the home's policy, titled, " Complaints and Customer Service, LRC-09-01-04", last updated in December 2019. The policy indicated that when the home received a complaint, they were where required by provincial, regional, local health or other authorities, to submit an incident report within required timeframes. In addition, Inspector #693 reviewed the home's policy, titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, LRC-02-01-02", last updated in 2019. The policy indicated that in Ontario, anyone who suspected or witnessed incompetent care or treatment of a resident that caused or may cause harm to the resident was required to contact the MOHLTC through the Action Line. The policy identified that the DOC or designate was responsible for following province specific reporting requirements. Inspector #693 reviewed Appendix 2, titled, "Jurisdictional Reporting Requirements", last updated in June 2019, the appendix identified that mandatory reporting under the LTCHA: Section 24 (1) of the LTCHA required a person to make an immediate report to the Director where there is reasonable suspicion that certain incidents occurred or may have occurred. The LTCHA provided that any person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident occurred, must have immediately reported the suspicion and the information upon which it was based to the Director of the MOHLTC.

During an interview with the DOC, they indicated they were familiar with the complaint from resident #037's SDM, and that this was not reported as a CIS, as the home had followed all of their policies so there was no indication that anything was wrong. During the interview, the DOC acknowledged that aspects of the complaint, specifically the delay in treatment of the area of impaired skin integrity, would be considered an allegation of improper and incompetent care, and should have been immediately reported to the Director. [s. 24. (1) 1.]

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

Subsection 152 (2) of the Long-Term Care Homes Act, 2007, states that "where an inspector finds that a staff member has not complied with subsection 24 (1) or

26 (1), the licensee shall be deemed to have not complied with the relevant subsection".

The home's policy "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting - RC-02-01-02", last updated June 2019, stated that "any employee or person who becomes aware of an alleged, suspected, or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at the time". The policy goes on to state that in Ontario, "anyone who suspects or witnesses abuse … is required to contact the [Ministry of Long Term Care] (Director) through the Action Line".

A CIS report was submitted by the home to the Director on an identified date, related to an alleged incident of verbal abuse that occurred on an identified date. A review of the home's investigation notes related to the incident indicated that Housekeeper #126 alleged to have overheard RHW #125 being verbally abusive to resident #043.

Inspector #757 conducted an interview with Housekeeper #126, who stated that they were not aware at the time of the incident of the requirement to immediately report the alleged incident of abuse. The Housekeeper stated "I admit that I made a mistake because I didn’t report it right away. Now I know the steps."

During an interview with CM #117, they indicated that the alleged incident of abuse should have been reported immediately on the day that the incident occurred. The CM further indicated that the Housekeeper had not reported the incident to them until the following day when they then submitted the CIS report. (757) [s. 24. (1) 2.]

3. A CIS report was submitted to the Director on an identified date, for an incident of staff to resident verbal abuse that had occurred on an identified date. The CIS report identified that PSW #134 had reported to CM #109, on an identified date, an incident that had occurred on an identified date, in which PSW #135 had sworn at resident #026.

The LTCHA 2007, 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.”

During an interview, PSW #134 reported that they had told CM #109 about this incident on an identified date, when they were being asked questions about another incident. They further added that they had not reported this incident right away.

During an interview, CM #109 confirmed to the inspector that this incident of verbal abuse had not been reported immediately. They further added that the home's policy on mandatory reporting had not been followed. (196) [s. 24. (1) 2.]

4. A CIS report was received by the Director on an identified date, related to staff to resident neglect of resident #005 and #006. The report alleged that resident #005 was found, after lunch, without care interventions in place. Resident #006 was also found, after lunch, without care interventions in place.

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 jeopardizes the health, safety or well-being of one or more residents."

A review of an email from PSW #136 to CM #100, sent two days after the incident, indicated that PSW #137 had reported to them that they found resident #005 without care interventions in place; it was the second occurrence with a specific staff member; and they believed that the resident did not accept care from specified staff members. The email further indicated an incident from the day before where PSW #137 reported to them that they found resident #006 in their ambulation device, without care interventions in place.

During an interview with PSW #137, they advised Inspector #577 that they had found resident #005 without care interventions in place, when they checked them at an identified time. Their co-worker found resident #006 to be without care interventions in place, at another identified time. They further reported that they informed RPN #138.

During an interview with RPN #138, they advised Inspector #577 that PSW #137 informed them about care concerns related to resident #005 and #006, and they didn't report it as "they would rather work with team members first before reporting and would only report life and death situations".

During an interview with PSW #136, they advised Inspector #577 that PSW #137 had reported to them that they found resident #005 without care interventions in place, and that resident #006 was also found without care interventions in place. They reported that PSW #137 didn't report these incidents to the RPN, so they sent an email to the CM #100.

During an interview with CM #100, they advised that PSW #139 neglected to have provided specificcare for resident #005 and #006 and PSW #136 and RPN #138 had not immediately reported alleged resident neglect. (577) [s. 24. (1) 2.]

5. A CIS report was received by the Director on an identified date, related to alleged staff to resident abuse. The report indicated verbal abuse towards resident #001 by PSW #140

Ontario Regulation 79/10 defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident."

A review of an email from PSW #141 to Interim Clinical Manager #102, and the Administrator, identified that it was sent during the evening after the incident. The email indicated that there was verbal abuse from PSW #140 towards resident #001, which may have indirectly led to an injury to the resident.

During an interview with PSW #141, they advised Inspector #577 that they witnessed PSW #140 abuse resident #001 and they didn’t immediately report it; they sent an email to Interim Clinical Manager #102 that evening, and acknowledged that they should have reported it immediately.

During an interview with Interim Clinical Manager #102, they advised Inspector #577 that an email from PSW #141 was sent the evening after the incident, and it had not been reported immediately. The Interim Clinical Manager advised that PSW #141 should have immediately reported the abuse when it had occurred. (577) [s. 24. (1) 2.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 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 to have his or her participation in decision-making respected.

A complaint was received by the Director on an identified date, related to care concerns for resident #042. The report alleged improper care of resident #042 during a specified activity, and the incorrect administration of a specified procedure

A review of the home's policy, "Code Blue in Long-Term Care - IMS -03-013", revised June 9, 2020, indicated that staff do not provide basic life support or call the ambulance if the resident had a completed "Do Not Resuscitate Confirmation Form" on their chart or if the arrest was unwitnessed; in the event of resuscitation, staff were to have provided basic life support (chest compressions and head tilt/chin lift only) until the resident responds or the transfer of care to paramedics.

A review of the home's policy, "Code Blue-Cardiac Arrest/Medical Emergency Plan", revised October 2018, indicated that staff were to have confirmed the wishes of the resident/Substitute Decision-Maker regarding resuscitation, and continue basic life support until transfer of care to the paramedics.

A review of the home's investigation notes indicated that resident #042 who was considered a certain status, had been found unwitnessed in an identified condition ; a specified procedure was initiated and done by RN #131, for a specified amount of time, and RN #132 directed staff to stop the specified procedure as it was an unwitnessed event; approximately a specified number of minutes later, the paramedics arrived, they re-initiated the specified procedure and pronounced the resident deceased a short time later.

During an interview with RN #131, they advised Inspector #577 that registered staff discussed advance directives and treatment directives with residents and/or family. RN #131 reported that that they do not explain that resuscitation would only occur if a staff member witnessed them take their last breath.

During an interview with RN #132, they advised Inspector #577 that they recalled discussions during RN meetings about not resuscitating a resident if the event was unwitnessed, and that they don't explain to the resident and/or family that staff would have to have witnessed them take their last breath.

During an interview with RN #133, they advised Inspector #577 that they haven't had discussions with residents or family about not resuscitating in an unwitnessed event and did not think that staff had been informing family or residents. They further advised that the "Code Blue" policy changed due to Covid, to have included information that if a resident was found unwitnessed without a pulse or breathing, they would not have been resuscitated; and previous to the new policy, residents would have been resuscitated, in an unwitnessed event.

During an interview with the Administrator, they advised Inspector #577 that the policy for "Code Blue" was updated in June 2020, as part of the Pandemic Planning, to protect staff with identifying proper PPE. They advised that it had been past practice to not resuscitate a resident if their last breath was unwitnessed, and it was not included in the previous "Code Blue" policy. The Administrator referred the Inspector to a Memo and policy directive, "Policy on Cardio-Pulmonary Resuscitation (CPR) and Do Not Resuscitate (DNR) Orders in Ontario Long-Term Care Facilities", dated March 7, 2002, from the Ministry of

Health and Long-Term Care. The Administrator and Inspector reviewed the policy together, and they confirmed that the policy had not given direction that a resident was not to be resuscitated if the event was unwitnessed. The inspector discussed that staff had not been having discussions with residents and/or families about not resuscitating if their last breath had been unwitnessed. They confirmed that residents rights to participate in their decision making related to resuscitation was not being respected and promoted. [s. 3. (1) 9.]

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 following rights of residents are fully respected and promoted: Every resident has the right to have his or her participation in decision-making respected, to be implemented voluntarily.

WN #3: 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 when they received a written or verbal complaint concerning the care of a resident or the operation of home, a response

was be made to the person who made the complaint, indicating what the licensee had done to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief.

Two CIS reports were received by the Director on an identified date, related to a written complaint received by the home from a family member of resident #003. The CI report indicated that resident #003 had complained that staff had provided rough care, during a specific care activity, and an identified area of their body was sore.

A review of the home's policy, titled, “Complaints and Customer Service, LRC-09-01-04", last updated in December 2019, indicated that the department manager or designate was to provide a written response to the complainant, that indicated if the complaint was unfounded, and reasons why this conclusion was reached; the home was to ensure that the timelines for responding to verbal/written complaints were followed and a written response was to be provided at the conclusion of the investigation; the written response was to include what the home had done to resolve the complaint and would be shared with the complainant/resident.

A review of the complaint submitted by the family member indicated specified care concerns and a complaint that staff had provided rough care, during a specific care activity, and an identified area of the resident's body was sore. Additionally, the complainant requested confirmation that the resident was being assisted with a specific activity from the staff.

A review of the written response to the complainant indicated that they would be discussing the matter with the staff involved with the resident’s care to determine what had happened, the circumstances surrounding the event and would take necessary steps to limit the likelihood that such a situation would occur again.

During an interview with CM #109, they advised Inspector #577 that their written response to the complainant had not included what they had done to resolve the complaint or whether the home determined the complaint to be founded or unfounded. [s. 101. (1) 3.]

2. See WN #1, finding #1, for further details.

Inspector #693 reviewed the home’s investigation into this complaint, and identified that Clinical Manager #100 completed this investigation, and responded

in writing to the complainant on an identified date. The letter of response, indicated that an investigation was conducted, and specific areas of the resident's medical record were reviewed, additionally that the home had followed the specific program accordingly, an OT completed an assessment in an appropriate timeframe, and in regards to the pain assessments, the physician was contacted to review the resident's current medication regime. During a review of the letter of response, Inspector #693 identified that the letter did not indicate if steps were taken to resolve this complaint, or if the complaint was unfounded, and the reasons the home believed this.

During an interview with CM #100, they stated that this complaint was unfounded, and they had a log on everything that was done for this resident, related to their area of impaired skin integrity, including the involvement of OT, and pain management. CM #100 reviewed the letter of response, to resident #027's SDM, and indicated that the letter of response did not explain that their complaint was unfounded and the reasons why, but did indicate some basic details about items that were looked at as part of the investigation. The CM indicated that the home typically didn't write in the letter of response if a complaint was unfounded, or give extensive details in writing, rather they have a call with the complainant to go over that information, before sending the letter. The CM indicated that for this complaint, they were not involved in the telephone call to the complainant, as that was done by the former VP of Seniors Health, and the Administrator.

During an interview with the Director of Care (DOC), they indicated that when the home received a written or verbal complaint, they had a complaint policy that they followed. They stated that if the complaint was unfounded, they do not usually write that in their letter of response to the complainant, as they have a general template that they followed, and usually they call the complainant to review the investigation, and that is where they would go into more detail about the investigation. [s. 101. (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 when they receive a written or verbal complaint concerning the care of a resident or the operation of home, a response is made to the person who made the complaint, indicating what the licensee had done to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief, to be implemented voluntarily.

Issued on this 28th day of September, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MELISSA HAMILTON (693) - (A1)
Inspection No. / No de l'inspection :	2020_768693_0012 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	004599-20, 005139-20, 005906-20, 007611-20, 010353-20, 013183-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 28, 2020(A1)
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
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sheila Clark

Ontario

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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

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 # / No d'ordre: 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. 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Order / Ordre :

The licensee must be compliant with s. 24. (1) of the Long Term Care Homes Act, 2007.

Specifically, the licensee must ensure that 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 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

Grounds / Motifs :

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

The home submitted a record of a verbal complaint, to the Director, on an identified date, as well as the home's response to the complainant on another identified date. The record of verbal complaint indicated that the Substitute Decision Maker (SDM), for resident #037, had made a verbal complaint to the Administrator, on an identified date. The complainant indicated that resident #037 had developed a area of impaired skin integrity, and treatment was not timely, subsequently the area of impaired skin integrity became infected and progressed. The complainant further indicated that the resident had been referred to an Occupational Therapist (OT), and was not seen in a timely manner, and in addition that the resident had an overall decline in condition, and the staff did not educate the family that this decline may have been a result of the area of impaired skin integrity and increased pain. Lastly that the resident had increased pain, and the pain was not managed.

During an Interview with CM #100, they acknowledged that the complaint made on an identified date, from resident #037's SDM, was regarding alleged improper and incompetent care, and that a Critical Incident System (CIS) report should have been immediately submitted to the Director, for this allegation, but was not.

Inspector #693 reviewed the home's policy, titled, " Complaints and Customer Service, LRC-09-01-04", last updated in December 2019. The policy indicated that when the home received a complaint, they were where required by provincial, regional, local health or other authorities, to submit an incident report within required timeframes. In addition, Inspector #693 reviewed the home's policy, titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, LRC-02-01-02", last updated in 2019. The policy indicated that in Ontario, anyone who suspected or witnessed incompetent care or treatment of a resident that caused or may cause harm to the resident was required to contact the MOHLTC through the Action Line. The policy identified that the DOC or designate was responsible for following province specific reporting requirements. Inspector #693 reviewed Appendix 2, titled, "Jurisdictional Reporting Requirements", last updated in June 2019, the appendix

identified that mandatory reporting under the LTCHA: Section 24 (1) of the LTCHA required a person to make an immediate report to the Director where there is reasonable suspicion that certain incidents occurred or may have occurred. The LTCHA provided that any person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident occurred, must have immediately reported the suspicion and the information upon which it was based to the Director of the MOHLTC.

During an interview with the DOC, they indicated they were familiar with the complaint from resident #037's SDM, and that this was not reported as a CIS, as the home had followed all of their policies so there was no indication that anything was wrong. During the interview, the DOC acknowledged that aspects of the complaint, specifically the delay in treatment of the area of impaired skin integrity, would be considered an allegation of improper and incompetent care, and should have been immediately reported to the Director. [s. 24. (1) 1.]
(693)

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

Subsection 152 (2) of the Long-Term Care Homes Act, 2007, states that "where an inspector finds that a staff member has not complied with subsection 24 (1) or 26 (1), the licensee shall be deemed to have not complied with the relevant subsection".

The home's policy "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting - RC-02-01-02", last updated June 2019, stated that "any employee or person who becomes aware of an alleged, suspected, or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at the time". The policy goes on to state that in Ontario, "anyone who suspects or witnesses abuse … is required to contact the [Ministry of Long Term Care] (Director) through the Action Line".

A CIS report was submitted by the home to the Director on an identified date, related to an alleged incident of verbal abuse that occurred on an identified date. A review of the home's investigation notes related to the incident indicated that Housekeeper #126 alleged to have overheard RHW #125 being verbally abusive to resident #043.

Inspector #757 conducted an interview with Housekeeper #126, who stated that they were not aware at the time of the incident of the requirement to immediately report the alleged incident of abuse. The Housekeeper stated "I admit that I made a mistake because I didn't report it right away. Now I know the steps."

During an interview with CM #117, they indicated that the alleged incident of abuse should have been reported immediately on the day that the incident occurred. The CM further indicated that the Housekeeper had not reported the incident to them until the following day when they then submitted the CIS report. (757) [s. 24. (1) 2.] (693)

3. A CIS report was submitted to the Director on an identified date, for an incident of staff to resident verbal abuse that had occurred on an identified date. The CIS report identified that PSW #134 had reported to CM #109, on an identified date, an incident that had occurred on an identified date, in which PSW #135 had sworn at resident #026.

The LTCHA 2007, 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."

During an interview, PSW #134 reported that they had told CM #109 about this incident on an identified date, when they were being asked questions about another incident. They further added that they had not reported this incident right away.

During an interview, CM #109 confirmed to the inspector that this incident of verbal abuse had not been reported immediately. They further added that the home's policy on mandatory reporting had not been followed. (196) [s. 24. (1) 2.]
(693)

4. A CIS report was received by the Director on an identified date, related to staff to resident neglect of resident #005 and #006. The report alleged that resident #005 was found, after lunch, without care interventions in place. Resident #006 was also found, after lunch, without care interventions in place.

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 jeopardizes the health, safety or well-being of one or more residents."

A review of an email from PSW #136 to CM #100, sent two days after the incident, indicated that PSW #137 had reported to them that they found resident #005 without care interventions in place; it was the second occurrence with a specific staff member; and they believed that the resident did not accept care from specified staff members. The email further indicated an incident from the day before where PSW #137 reported to them that they found resident #006 in their ambulation device, without care interventions in place.

During an interview with PSW #137, they advised Inspector #577 that they had found resident #005 without care interventions in place, when they checked them at an identified time. Their co-worker found resident #006 to be without care interventions in place, at another identified time. They further reported that they informed RPN #138.

During an interview with RPN #138, they advised Inspector #577 that PSW #137 informed them about care concerns related to resident #005 and #006, and they didn't report it as "they would rather work with team members first before reporting and would only report life and death situations".

During an interview with PSW #136, they advised Inspector #577 that PSW #137 had reported to them that they found resident #005 without care interventions in place, and that resident #006 was also found without care interventions in place. They reported that PSW #137 didn't report these incidents to the RPN, so they sent an email to the CM #100.

During an interview with CM #100, they advised that PSW #139 neglected to have provided specificcare for resident #005 and #006 and PSW #136 and RPN #138 had not immediately reported alleged resident neglect. (577) [s. 24. (1) 2.] (693)

5. A CIS report was received by the Director on an identified date, related to alleged staff to resident abuse. The report indicated verbal abuse towards resident #001 by PSW #140

Ontario Regulation 79/10 defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident."

A review of an email from PSW #141 to Interim Clinical Manager #102, and the Administrator, identified that it was sent during the evening after the incident. The email indicated that there was verbal abuse from PSW #140 towards resident #001, which may have indirectly led to an injury to the resident.

During an interview with PSW #141, they advised Inspector #577 that they witnessed PSW #140 abuse resident #001 and they didn't immediately report it; they sent an

email to Interim Clinical Manager #102 that evening, and acknowledged that they should have reported it immediately.

During an interview with Interim Clinical Manager #102, they advised Inspector #577 that an email from PSW #141 was sent the evening after the incident, and it had not been reported immediately. The Interim Clinical Manager advised that PSW #141 should have immediately reported the abuse when it had occurred. (577) [s. 24. (1) 2.]

The decision to issue this Compliance Order (CO) was based on the scope which was a pattern, the severity which was minimal harm or risk. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:

-a Written Notification (WN) was issued from a Critical Incident System (CIS) Inspection #2020_633577_0008 on June 9, 2020;
-a WN was issued from a CIS Inspection #2020_655679_0003 on February 7, 2020;
-a WN was issued from a CIS Inspection #2019_740621_0036 on January 6, 2020;
-a WN was issued from a Complaint Inspection #2019_740621_0037 on January 6, 2020;
-a Compliance order (CO) was issued from a Complaint Inspection #2019_633577_0010 on June 4, 2019; and
-a WN was issued from a CIS Inspection #2017_509617_0017 on October 11, 2017. (693)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 05, 2020(A1)

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

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 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:

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

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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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 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 28th day of September, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by MELISSA HAMILTON (693) - (A1)

Ontario

Ministry of Long-Term Care

Ministère 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

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