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_0011 (A1)	002490-20	Follow up

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.

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The purpose of this inspection was to conduct a Follow up inspection.

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

The following intake was inspected upon during this Follow up inspection:

-log #002490-20, related to CO#001 from inspection #2020_655679_0003, issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 19. (1).

Critical Incident System (CIS) inspections #2020_768693_0013, and #2020_768693_0014, and Complaint inspection #2020_768693_0012 were conducted concurrently with this Follow up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), a Clinical Manager (CM), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

Ad-hoc notes were used during this inspection.

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 failed to ensure that residents were not neglected by the licensee or staff.

Inspector #693 was following up on the home's outstanding Compliance Order #001 issued during Inspection #2020_655679_0003 with a compliance date of February 25, 2020.

The home was ordered to be in compliance with s. 19. (1) of the Long Term Care Homes Act, 2007. Specifically, the licensee was ordered to ensure that residents of the home were protected from abuse by anyone and to have ensured that residents were not neglected by the licensee or staff.

A Critical Incident System (CIS) report was submitted by the Director, on an identified date, for the improper or incompetent treatment of resident #032 on an identified date. The report further indicated that on an identified date, it was reported that resident #032 sustained a fall at a specified time, that resulted in an area of altered skin integrity to an identified area of the resident's body, and another area of altered skin integrity to another identified area of the resident's body. The CIS report further indicated, that on an identified date, the SDM of resident #032, reported to CM #109, that they were concerned that resident #032 was not checked on for some time, as the resident reported to them that they laid on the floor for an identified amount of time prior to getting help.

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 #693 reviewed the home's policy, titled "Zero Tolerance of Resident Abuse and Neglect Program, LRC-02-01-01", last updated in October, 2019. The policy identified that the home was committed to providing a safe and secure environment, in which all residents were treated with dignity and respect and were protected from all forms of abuse or neglect at all times. Additionally, the policy stated that neglect was the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being- includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. The policy listed lack of necessary safety precautions to prevent injury to the resident, as a form of neglect.

Inspector #693 obtained a copy of the home's policy, titled "Care and Comfort Rounds, LRC-12-01-06”, last updated on December 18, 2019. The policy indicated that hourly rounding was to be completed by staff.

Inspector #693 reviewed resident #032’s care plan, that was in place on an identified date. The care plan, effective an identified date, indicated that the

resident had a specified impairment, required a specified level of assistance with transferring, and bed mobility, and was at risk for falls.

Inspector #693 reviewed the home's CIS investigation file. The file contained staff schedules that indicated that RPN #107, and PSW #108, had worked a specified shift, on the floor where resident #032 resided. The file included notes from CM #109, that indicated they had reviewed video footage from an identified date, and visualized that at a specified time, PSW #108 was seen leaving resident #032's room and closed their door, most of the night RPN #107 and PSW #108 were seen sitting at the nurse's station, and at a specified time, RPN #107 entered resident #032's room. The investigation notes identified that at an identified time, RPN #107, heard resident #032 calling for help, entered their room, and found the resident in an identified position, with an area of altered skin integrity to an identified area of the resident's body, and another area of altered skin integrity to another identified area of the resident's body. Additionally, the notes indicated that between an identified time and an identified time, neither RPN #107 or PSW #108 entered resident #032's room. Inspector #693 further reviewed the home's investigation file, and identified letters to both RPN #107, and PSW #108, that resulted in a specified result for both staff members, as well as re-education on the home's zero tolerance of abuse and neglect policy. The letters indicated they were regarding the fall of a resident on an identified date, who sustained an injury, and that during this shift, neither RPN #107 or PSW #108 completed hourly checks on the resident, and the resident subsequently laid on the floor for an identified amount of time prior to receiving help. In addition, the investigation notes indicated that CM #109 interviewed resident #032, who told them they laid on the floor for an identified amount of time before they received help up.

During an interview with RPN #110, they indicated that on night shifts there is one RPN and one PSW assigned to a unit. The RPN indicated that it was the responsibility of both the RPN and PSW to ensure that each resident is checked on hourly, by visualizing the resident.

During an interview with PSW #108 they indicated that it was the home's policy for resident's to be checked on hourly, during all shifts. PSW #108 stated that on an identified shift, they had checked on resident #032 at an approximate time, and then not again until another approximate time; when RPN #107 heard the resident calling for help and found resident #032 in an identified position, as they had sustained a fall with injury. The PSW indicated that RPN #107 and PSW #108 had missed room checks that night.

During separate interviews with CM #109 and the DOC, they indicated that on an identified date, resident #032 sustained a fall with injury, and the home's investigation determined that the resident had laid on the floor for an identified amount of time. The DOC and CM #109 indicated that RPN #107 and PSW #108 did not follow the home's "Care and Comfort Rounds" policy, as they did not check on resident #032 hourly, and subsequently that this incident was founded for neglect.

As a result of this finding of non-compliance, CO #001 from inspection #2020_655679_0003 will be re-issued. [s. 19. (1)]

2. The licensee has failed to ensure that residents were protected from abuse and neglect by the licensee or staff.

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 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.

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.

Ontario Regulation 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 review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect Program, LRC-02-01-01", last updated in October, 2019, indicated that the home was committed to having provided 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. They 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, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting - LRC-02-01-02", revised on October 23, 2019, indicated that anyone who witnessed or suspected abuse or neglect by another resident, staff or other person must notify management immediately; any employee or person 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 the time; the person reporting the suspected abuse would follow the home's reporting process and provincial requirements to ensure the information was provided to the home Administrator or designate immediately.

An email from PSW #141 to Interim Clinical Manager #102 and the Administrator, sent during the evening after the incident, was reviewed by the Inspector. 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.

A review of the home's investigation file concerning PSW #140, included the following documentation:

-an interview with PSW #141, which indicated that resident #001 was in a specified location, when PSW #140 entered the identified area. They overheard PSW #140 tell the resident what they were doing, the resident was upset, and there was raised voices between the resident and PSW. PSW #141 overheard PSW #140 state, an identified threatening statement; they moved the resident in their ambulation device from one location to another. After PSW #141 assisted with the care of another resident, they went back to resident #001's room and observed that the resident had an area of altered skin integrity, on an identified area of their body; there was an identified substance smeared on door; the door was off track and appeared that they slid their identified area of their body through and attempted to open the identified door. PSW #141 asked PSW #140 whether they grabbed the resident and they reported that the resident had pushed the door off the tracks and it was off the hinge as the resident attempted to get back into an identified location; PSW #140 stated, an identified verbally abusive statement with the use of an expletive.

-notes of a phone video recording taken by PSW #141, which was part of the verbal altercation between resident #001 and PSW #140's verbal interaction. In the recording, they were heard yelling an identified verbally abusive statement with the use of an expletive, at the resident, and another resident.

-an interview with PSW #140, Interim Clinical Manager #102 and Human Resources indicated that PSW #140 reported that resident #001 had rammed their ambulation device into them, grabbed them and punched them in their rib cage. Stated they (PSW) were ‘in a fit of rage’;

-investigation findings concluded that the evidence obtained during the investigation confirmed that PSW #140 verbally and emotionally abused a resident under their care. In addition, they moved the resident out of the an identified area and into another identified area, that was dark; they didn't turn on a light and shut the door, effectively physically restraining them in their bedroom. The resident tried to get back into the identified area and suffered an area of altered skin integrity; and,

- an identified letter, from Interim Clinical Manager #102 to PSW #140 which indicated that as a result of the investigation, and by their own admission, they determined that on an identified date, they engaged in a verbal conflict with a resident. They spoke in a raised voice with an angry tone, they threatened the resident and physically restrained the resident in their room with the door closed. Their actions constituted verbal and emotional abuse of a resident.

During an interview with PSW #140, they advised Inspector #577 that resident #001 became agitated when they were in the identified area and punched the PSW in the stomach; they were yelling at the resident and didn't remember what they said but stated they ‘blew up at them’; they moved them in their ambulation device into another identified area and closed the identified door to get away from them. The PSW reported that the resident was screaming at them and accused them of scratching an identified area of their body. The PSW further reported that the resident cut an identified area of their body on the specified door, as they removed the door off the track. They advised the inspector that they abused resident #001.

During an interview with PSW #141, they advised Inspector #577 that they overheard PSW #140 state an identified threatening statement to to resident #001, from the identified room; reported that the resident was in the identified

room when PSW #140 interrupted them to get an identified item; they took them out of the identified area in their ambulation device and shut the specified door. PSW #141 reported that after the care of another resident, they checked on resident #001, and found an identified area of their body was in an identified condition; they called PSW #140 into their room and asked them if they had caused the injury; advised that PSW #140 yelled at resident #001, an identified verbally abusive statement. As they stormed out of the resident's room, they yelled at another resident, a verbally abusive statement with the use of expletives. The PSW advised the inspector that they recorded the interaction. PSW #141 reported to Inspector #577 that 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 manager reported that through the investigation, it was determined that PSW #140 had verbally and emotionally abused resident #001 and was terminated. (577) [s. 19. (1)]

3. See WN #3, finding #2, WN #5, finding #1, and WN #9, in Critical Incident System (CIS) Inspection #2020_768693_0013 report, for further details.

Inspector #693 reviewed the home's policy, titled " Zero Tolerance of Resident Abuse and Neglect Program, LRC-02-01-01", last updated in October, 2019. The policy identified that the home was committed to providing a safe and secure environment, in which all residents were treated with dignity and respect and were protected from all forms of abuse or neglect at all times. Additionally, the policy stated that neglect was the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being- includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. The policy listed lack of necessary safety precautions to prevent injury to the resident.

Inspector #693 reviewed the home's policy, titled, "Pain Identification and Management, LRC-19-01-01", last updated on January 22, 2020. The policy indicated that when a resident experienced any new pain, they were to have a comprehensive pain assessment completed.

Inspector #693 reviewed the home's policy, titled, "Fall Prevention and

Management Program, LRC-15-01-01", last updated January 22, 2020. The policy indicated that after a resident fell, staff were required to complete an initial physical and neurological assessment, to have treated any injuries and managed pain, hold a post fall huddle, complete a post fall assessment, notify the SDM, and if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record." The policy also directed staff to assess the following; for 72 hours post fall, at each shift: pain, bruising, change in functional status, change in cognitive status; and changes in range of motion. In addition, the policy indicated on the 'Post Fall Clinical Pathway', that staff were to move the resident using a mechanical lift after a fall, following assessment by the nurse and approval for transfer.

Inspector #693 reviewed the home's CIS investigation file. The investigation notes indicated that through investigation, which included interviews and a review of video surveillance, the home determined that RPN #112 did not complete an assessment of resident #029, post fall on an identified date, before instructing PSW #128 to help lift the resident to bed with a mechanical lift, did not complete any hands-on physical assessment of the resident at anytime post fall, did not notify resident #029's POA, did not call an RN to assess resident, did not complete a post-fall huddle, and did not fully complete the required post falls assessment. The investigation notes indicated that RPN #112 admitted they did not complete an assessment on resident #029, when they fell on an identified date, and that they did not report the fall to the RN or resident's SDM. A letter to RPN #112 was included in the file. The letter of indicated that management had met with the RPN on an identified date, to discuss RPN #112's response to a resident fall on an identified date, and that as a result of the home's investigation, and by the RPN's own admission, it was determined that the RPN failed to follow resident safety protocols and failed to complete a fall assessment on a resident who fell. In addition, the letter indicated that RPN #112 did not respond to signs and reports that the resident was in pain, and did not notify the RN, or resident's SDM. Further, the letter indicated that RPN #112's failure to follow protocol may have resulted in a delay in identifying and responding to the resident's injury, and that the RPN's actions constituted neglect.

During an interview with PSW #128, they indicated that they were working on an identified date, when resident #029 sustained a fall. The PSW stated that a Therapeutic Recreation staff member found the resident on the floor in the hallway in an identified location and called for help. PSW #128 stated that they attended to the resident with RPN #112, and RPN #112 instructed the PSW to get

the lift and help the RPN lift the resident into their bed. PSW #128 stated that RPN #112, did not complete an assessment of the resident, before the staff transferred the resident with a lift, and stated the RPN just looked at the resident. PSW #112 stated that it was obvious the resident was in pain, as they were saying they were and grabbing towards an identified area of their body. The PSW reported that once the resident was in bed, RPN #112 did not complete a further assessment, and this included not completing vital signs. The PSW stated that the resident told them they would like to go to the hospital as they were in pain, and the PSW reported this to the RPN. PSW #128 stated that RPN #112 did not do anything to treat resident #029's pain or attempt to send the resident for further assessments.

During an interview with the DOC, they indicated that the home had reported resident #112 to the College of Nurses of Ontario (CNO), for neglect relating to the fall of resident #028, as well as other incidents of staff to resident neglect that the RPN had been involved in.

Inspector #693 reviewed the DOC's report to the CNO, for RPN #112. The report, submitted on an identified date, indicated that on an identified date, RPN #112 neglected and abused a resident, on another identified date, RPN #112 neglected two residents, and that on another identified date, a resident who was in the care of RPN #112, experienced a fall, and RPN #112 stood over the resident for approximately 10 minutes, while waiting for a PSW to get a mechanical lift. Additionally, RPN #112 failed to follow the home's protocol after a fall and did not assess the resident post fall for injury, as well did not respond to signs and reports from other staff that the resident was experiencing pain. RPN #112 did not report the fall to the RN or resident's SDM. The report indicated that the consequence to the resident was a delay in identifying and responding to the residents' injury.

During an interview with the DOC, they stated that after resident #029 fell on an identified date, they were not properly assessed by RPN #112, and there was a delay in sending the resident to the hospital for further investigations. The DOC stated that the RPN failed to complete a physical assessment of the resident post fall, failed to assess and treat the resident's pain, transferred the resident post fall prior to completing an assessment, falsified the resident's vital signs, did not follows the policies outlined by the falls prevention and management program, and that their actions may have been cause for the extent of the resident's injuries. The DOC confirmed that RPN #112 had neglected resident #028, as well had a history of involvement in related incidents.

CO #001 was issued during inspection #2020_655679_0003, pursuant to the Long- Term Care Homes Act (LTCHA),2007, c.8, s. 19. (1) with a compliance due date of February 25, 2020. As the compliance date was not yet due at the time of the inspected Critical Incidents in findings #2 and 3, these findings will be issued as a WN to further support the order. [s. 19. (1)]

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

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_0011 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002490-20 (A1)
Type of Inspection / Genre d'inspection :	Follow up
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

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

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)

Linked to Existing Order / Lien vers ordre existant: 2020_655679_0003, CO #001;

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 compliant with section 19. (1) of the Long Term Care Homes Act, 2007.

Specifically, the licensee must ensure that residents of the home are protected
from abuse by anyone and shall ensure that residents are not neglected by the
licensee or staff.

Grounds / Motifs :

1. The licensee failed to ensure that residents were not neglected by the licensee or staff.

Inspector #693 was following up on the home's outstanding Compliance Order #001 issued during Inspection #2020_655679_0003 with a compliance date of February 25, 2020.

The home was ordered to be in compliance with s. 19. (1) of the Long Term Care Homes Act, 2007. Specifically, the licensee was ordered to ensure that residents of the home were protected from abuse by anyone and to have ensured that residents were not neglected by the licensee or staff.

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date, for the improper or incompetent treatment of resident #032 on an identified date. The report further indicated that on an identified date, it was reported that resident #032 sustained a fall at a specified time, that resulted in an area of altered skin integrity to an identified area of the resident's body, and another area of altered skin integrity to another identified area of the resident's body. The CIS report further indicated, that on an identified date, the SDM of resident #032, reported to CM #109, that they were concerned that resident #032 was not checked on for some time, as the resident reported to them that they laid on the floor for an identified amount of time prior to getting help.

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Inspector #693 reviewed resident #032's care plan, that was in place on an identified date. The care plan, effective an identified date, indicated that the resident had a specified impairment, required a specified level of assistance with transferring, and bed mobility, and was at risk for falls.

Inspector #693 reviewed the home's CIS investigation file. The file contained staff schedules that indicated that RPN #107, and PSW #108, had worked a specified

shift, on the floor where resident #032 resided. The file included notes from CM #109, that indicated they had reviewed video footage from an identified date, and visualized that at a specified time, PSW #108 was seen leaving resident #032's room and closed their door, most of the night RPN #107 and PSW #108 were seen sitting at the nurse's station, and at a specified time, RPN #107 entered resident #032's room. The investigation notes identified that at an identified time, RPN #107, heard resident #032 calling for help, entered their room, and found the resident in an identified position, with an area of altered skin integrity to an identified area of the resident's body, and another area of altered skin integrity to another identified area of the resident's body. Additionally, the notes indicated that between an identified time and an identified time, neither RPN #107 or PSW #108 entered resident #032's room. Inspector #693 further reviewed the home's investigation file, and identified letters to both RPN #107, and PSW #108, that resulted in a specified result for both staff members, as well as re-education on the home's zero tolerance of abuse and neglect policy. The letters indicated they were regarding the fall of a resident on an identified date, who sustained an injury, and that during this shift, neither RPN #107 or PSW #108 completed hourly checks on the resident, and the resident subsequently laid on the floor for an identified amount of time prior to receiving help. In addition, the investigation notes indicated that CM #109 interviewed resident #032, who told them they laid on the floor for an identified amount of time before they received help up.

During an interview with RPN #110, they indicated that on night shifts there is one RPN and one PSW assigned to a unit. The RPN indicated that it was the responsibility of both the RPN and PSW to ensure that each resident is checked on hourly, by visualizing the resident.

During an interview with PSW #108 they indicated that it was the home's policy for resident's to be checked on hourly, during all shifts. PSW #108 stated that on an identified shift, they had checked on resident #032 at an approximate time, and then not again until another approximate time; when RPN #107 heard the resident calling for help and found resident #032 in an identified position, as they had sustained a fall with injury. The PSW indicated that RPN #107 and PSW #108 had missed room checks that night.

During separate interviews with CM #109 and the DOC, they indicated that on an identified date, resident #032 sustained a fall with injury, and the home's investigation

determined that the resident had laid on the floor for an identified amount of time. The DOC and CM #109 indicated that RPN #107 and PSW #108 did not follow the home's "Care and Comfort Rounds" policy, as they did not check on resident #032 hourly, and subsequently that this incident was founded for neglect.

As a result of this finding of non-compliance, CO #001 from inspection #2020_655679_0003 will be re-issued.

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 one, as the incident was isolated. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:

- a CO issued in February 2020, during inspection #2020_655679_0003;
- a Written Notification (WN) issued September 2019, during inspection 2019_768693_0021;
- a CO issued August, 2019, during inspection #2019_746692_0019;
- a CO issued October 2018, during inspection #2018_624196_0023; and,
- a CO issued October 2017, during inspection #2017_509617_0017;

(679) (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