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
Feb 4, 2022	2022_914196_0004	020451-21, 020669-21, 020919-21, 000001-22, 000658-22, 000797-22, 000803-22, 001201-22	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

LAUREN TENHUNEN (196), MELISSA HAMILTON (693)

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): January 24 to 28, and 31, 2022.

The following intakes were inspected on during this Critical Incident System (CIS) inspection:
-one intake related to an allegation of improper resident care;
-two intakes related to allegations of staff to resident neglect;
-three intakes related to resident to resident abuse;
-one intake related to a resident fall with injury; and
-one intake related to a resident elopement.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers (CMs), Infection Prevention and Control Facilitator (IPAC Facilitator), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Home Workers (RHWs), Housekeeping Aides and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed Infection Prevention and Control (IPAC) practices, reviewed relevant health care records, reviewed the home's internal investigation notes, and reviewed licensee policies and procedures.

Critical Incident System Inspection was conducted concurrently with Complaint Inspection #2022_914196_0003.

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

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

- **3 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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A resident's plan of care indicated that staff were to follow specific strategies when providing care to the resident.

The Critical Incident System (CIS) report outlined an allegation of improper care of a resident by staff when they had provided care.

Two Personal Support Workers (PSWs) reported that a resident had displayed responsive behaviours when they had provided care; they proceeded with care; and they reported they had not provided improper care of the resident.

A Clinical Manager (CM) reported that the staff had not followed the resident's plan of care which indicated strategies to follow if the resident displayed specific behaviours.

Sources: A CIS report; Long-Term Care Home's (LTCH's) CIS investigation file; a Resident's plan of care; observations of a resident; and interviews with two PSWs and a CM [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 that ensures the care set out in the plan of care is provided to residents as specified in their plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was not neglected by staff.

O. Reg. 79/10, s. 5, defined 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 resident was not provided with assistance with an activity of daily living (ADL) by a PSW after they had been informed of the need by an RPN.

A CM had determined that the resident had not received assistance with an ADL by a PSW, when they were informed by an RPN of the resident’s need. Additionally, the PSW had not provided any care during the shift for this resident. Two PSWs had also been aware of the resident's need for assistance with an ADL, but had not provided care. The RPN had not followed up with the PSWs to ensure the care was provided as required.

Sources: CIS report; Resident plan of care, Point of Care flow sheets; LTCH's CIS investigation file; policy titled, "Zero Tolerance of Resident Abuse and Neglect Program, LRC-02-01-01" (dated, June 2021); interviews with a CM, a PSW, and other relevant staff members. [s. 19. (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 that ensures residents are not neglected by staff, to be implemented voluntarily.

WN #3: 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 physical abuse between residents was immediately reported to the Director.

An incident occurred between two residents which resulted in an injury.

The CIS report was submitted to the Director.

The CM indicated that the incident was not reported to the Director, until the day after the incident.They further reported that the RPN had not reported it to the RN at the time of the incident, as was required.

Sources: CIS report; LTCH's investigation file; policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting - RC-02-01-02" (dated June 2021); interviews with a CM, an RPN and other relevant staff members. [s. 24. (1)]

2. The licensee has failed to ensure that neglect of a resident was immediately reported to the Director.

An RPN became aware of an incident of neglect involving a resident.

A CIS report was submitted to the Director on the following date.

The CM indicated that the incident was not reported to the Director, until the following day. The RPN had not reported it to the RN and it was not reported to the Ministry until the following day when the CM had read an email outlining the incident.

Sources: CIS report; LTCH's investigation file; policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting - RC-02-01-02" (dated June 2021); interviews with a CM, an RPN and other relevant staff members. [s. 24. (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 that ensures 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, is reported immediately to the Director, to be implemented voluntarily.

Issued on this 4th day of February, 2022

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

Original report signed by the inspector.