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

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
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Original Public Report

Report Issue Date August 30, 2022
Inspection Number #2022_1407_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
St. Joseph's Care Group

Long-Term Care Home and City
Hogarth Riverview Manor, Thunder Bay

Lead Inspector
Shannon Russell #692

Inspector Digital Signature
Shannon K Russell
Digitally signed by Shannon K Russell
Date: 2022.09.02 13:36:33 -04'00'

Additional Inspector(s)
Tracy Muchmaker #690, Lauren Tenhunen #196, Chris Amonson #721027

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 20-24, 2022.

The following intake(s) were inspected:

- Four intakes, related to complaints submitted regarding resident care concerns,
- Nine intakes, related to resident-to-resident physical aggression, and
- Four intakes, related to allegations of staff to resident abuse.

The following **Inspection Protocols** were used during this inspection:

- Continence Care
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours
- Skin and Wound Prevention and Management

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable. There were findings of non-compliance.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

1. Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that an allegation of abuse towards a resident was immediately reported to the Director.

Rationale and Summary
A resident reported that a specific area of their body was sore, from when a Personal Support Worker (PSW) was assisting them with care. An assessment was completed, and the resident was diagnosed with a significant injury.

The resident identified that the PSW had been rough, which caused the significant injury. Another PSW identified that they had not reported what they suspected, and that the PSW had continued to work until the following shift.

The Clinical Manager (CM) identified that the allegation of abuse towards the resident by the PSW had not been reported immediately, and it should have been.

There was a low impact and a low risk to the resident for not reporting the allegation to the Director immediately.

Sources: Two CIS'; a resident's health care records; internal investigation notes; the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", #LRC-02-01-01, last revised June 2021; and interviews with the resident, a PSW, Registered Nurse (RN) and the CM. [692]

2. Non-compliance with: LTCHA, 2007, s. 24 (1) 2.

The licensee has failed to ensure that the allegations of abuse towards three residents by two PSWs were reported immediately to the Director.

Rationale and Summary
On two separate dates a resident had reported to a Registered Practical Nurse (RPN) that they had experienced abuse from a PSW.

The RPN witnessed the PSW complete inappropriate acts towards two residents on the same day.

The home's investigation concluded that the RPN had failed to report the incidents immediately. The investigation found that another PSW had disclosed to the RPN that they had witnessed the same PSW be inappropriate to another resident on a separate occasion, and that they themselves had also been inappropriate to the same resident in the past.

The CM indicated that the allegations of abuse by the PSW's towards three residents were not immediately reported.

Sources: CIS report; three residents health care records; LTC home's policies titled "Zero Tolerance of Resident Abuse and Neglect Program:RC-02-01-01" (updated: June 2021), "Zero Tolerance of Resident Abuse and Neglect Program: Response and Reporting: RC-02-01-02" (updated: June 2021), "Zero Tolerance of Resident Abuse and Neglect Program: Response and Reporting: RC-02-01-02" (updated: June 2021); internal investigation file; and interviews with the CM. [721027]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 79/10 s. 51 (2) (b) and O. Reg 246/22 s. 56 (2) (b)

The licensee has failed to ensure that a resident's individualized plan for continence care was implemented.

Rationale and Summary

A complaint was submitted regarding concerns that a resident's individualized continence plan had not been implemented. The complainant indicated that the resident was to have assistance with continence care at specific times of the day; however, on multiple occasions the resident had not been assisted, which resulted in the resident being incontinent.

The resident's care plan identified a specific continence plan, to be completed at specific times of the day.

The point of care (POC) documentation identified that the resident was not provided the required assistance on seven dates in the month reviewed. The progress notes indicated that there had been concerns brought forward by the resident and their substitute decision maker (SDM) regarding the resident not being provided the required assistance.

Direct care staff indicated that there had been occasions that staff were not able to provide the assistance required for the resident. The CM indicated that staff were to follow the resident's care plan for continence care to maintain their current continent status.

There was moderate impact and moderate risk to the resident by not following the resident's continence plan, as the resident had a decline in their continence level.

Sources: Complaint intake; the home's complaint log for the two months reviewed; a resident's health care records, including assessments, care plan and progress notes; the home's policy titled, "Continence Management Program", #LRC-14-01-01, last revised March 2022; and interviews with the resident, PSW, RN, and the CM. [692]

COMPLIANCE ORDER CO#001: INTEGRATION OF ASSESSMENTS, CARE

NC#03 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 6 (4) (a)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021, s. 6 (4) (a)

The licensee shall:

(a) Re-educate the RPN and those staff involved with the care of the resident on the process to be completed for nutritional monitoring, including the referral process when the resident has a decreased intake; and,
(b) Document the education provided, including the content of the material reviewed, the date completed, and the staff member who provided the education.

Grounds

1. Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that staff involved in the different aspects of care of a resident collaborated with each other, including timely assessment of the resident.

Rationale and Summary
A resident had a history of a specific diagnosis and was assessed to as a nutritional risk. During a nine-day period, the resident consumed less than their recommended daily intake.

An RPN, CM and the Director of Care (DOC), indicated that when a resident had less than their recommended dietary intake, a referral was to be sent to the Registered Dietitian (RD). A RPN indicated that no referral was sent to the RD for the resident's decreased intake; the RD confirmed they had not received a referral for the resident.

There was a high impact for the resident, as they had a significant diagnosis, and required further medical treatment. There was a high risk as the resident had not been assessed appropriately.

Sources: Complaint investigation file; a resident's health records; the home's policy titled Nutrition Monitoring: NC-04-01-05 (revised April, 2022); and interviews with a RPN, RD, CM, the DOC and a resident. [721027]

This order is to be complied by September 30, 2022

COMPLIANCE ORDER CO#002: DUTY TO PROTECT

NC#04 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007, s. 19 (1) and FLTCA, 2021, s. 24 (1)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with LTCHA, 2007, s. 19 (1) and FLTCA, 2021, s. 24 (1)

The licensee shall:

(a) Re-educate the identified PSWs and the RPN on zero-tolerance of abuse and neglect of residents, focusing on prevention and what constitutes abuse; and,
(b) Document the education provided, including the content of the material reviewed, the date completed, and the staff member who provided the education.

Grounds

1. Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from abuse by a PSW.

O. Reg. 246/22, s. 2 (1), defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain".

Rationale and Summary
A resident reported to their SDM and an RN that a specific area of their body was sore. The resident was assessed and diagnosed with a significant injury.

The resident identified that the PSW had been rough with them, which caused them to be upset and they had experienced a lot of pain.

A PSW indicated that they had observed another PSW be rougher than necessary with the resident. The PSW identified that they had not reported what they suspected, and that the PSW had continued to work until the following shift.

The CM identified that the allegation of physical abuse towards a resident by a PSW had been founded, as the resident had sustained a significant injury due to the actions by the PSW.

There was a high impact and a high risk to the resident as the resident had sustained a significant injury and the PSW had continued to provide care to the resident after the incident.

Sources: Two CIS'; a resident's health care records; internal investigation notes; the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", #LRC-02-01-01, last revised June 2021; and interviews with a resident, PSW, RN and the CM. [692]

2. Non-compliance with: LTCHA, 2007, s. 19 (1)

The licensee has failed to ensure that three residents were protected from abuse by two PSWs.

O. Reg. 79/10, s. 2 (1) (a), 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 are performed by anyone other than a resident.

Rationale and Summary
On two separate dates, a resident had reported to a RPN that they had experienced abuse by a PSW.

An RPN witnessed a PSW being inappropriate towards two residents at separate times on the same day. Later in that shift, the RPN emailed management the incidents of alleged abuse, and in the process another PSW disclosed to the RPN that they had witnessed the PSW being inappropriate to a different resident on a separate occasion.

The CM indicated that the allegations of abuse against the PSW towards the three residents were founded. Additionally, the CM stated the allegation of abuse by the second PSW was founded.

The impact to the residents were low with no reported lasting emotional or physical impacts, and the risk was high due to multiple incidents of abuse by the PSWs.

Sources: A CIS report; three resident's health care records; LTC home's policies titled "Zero Tolerance of Resident Abuse and Neglect Program: RC-02-01-01" (updated: June 2021), "Zero Tolerance of Resident Abuse and Neglect Program: Response and Reporting: RC-02-01-02" (updated: June 2021), "Zero Tolerance of Resident Abuse and Neglect Program:

Response and Reporting: RC-02-01-02" (updated: June 2021); internal investigation file; and an interview with the CM. [721027]	
This order is to be complied by September 30, 2022	

An Administrative Monetary Penalty (AMP) is being issued for this compliance order [AMP #001]

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NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with LTCHA, 2007, s. 19 (1) and FLTCA, 2021, s. 24 (1)

Notice of Administrative Monetary Penalty (AMP) #001
Related to Compliance Order #002

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **$5500.00,** to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for:

- The licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement, or

Compliance History

- Order #001 of Inspection #2020_768693_0011, LTCHA, 2007, s. 19 (1)

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

*Licensees must **not** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

COMPLIANCE ORDER CO#003: SAFE STORAGE OF DRUGS

NC#05 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s.138 (1) (a) (ii)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 138 (1) (a) (ii)

The Licensee shall:

(a) Re-educate the identified RPN on the process of medication administration, focusing on safe storage of medications; and,

(b) Retain a written record of the education provided, including the date and who provided the training.

Grounds

Non-compliance with: O. Reg 246/22 s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs were stored in a medication cart, that was secure and locked when unattended.

Rationale and Summary
During the inspection, Inspector #692 observed an unlocked medication cart that was stationed outside a resident's room, unattended with the second drawer open and observed multiple medications exposed and accessible. There was a resident who was self-propelling in a wheelchair, they appeared agitated and were calling out for staff.

Approximately 10 minutes later, a RPN exited a resident's room and returned to the unattended medication cart. The RPN identified that they had forgotten to lock the medication cart when they went into the resident's room, and it was to be locked when unattended.

The Administrator indicated that all medication carts were to be locked and secured when not supervised by the nurse.

Sources: Inspector #692's observation; the home's policy titled, "Administration of Medications – General Guidelines", #5.5, last revised March 2020; and interviews with the RPN, an RN, and the Administrator. [692]

This order is to be complied by September 30, 2022

COMPLIANCE ORDER CO#004: ALTERCATIONS AND OTHER INTERACTIONS BETWEEN RESIDENTS

NC#06 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 79/10 s. 54 (b) and O. Reg. 246/22 s. 59 (b)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

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Sudbury ON P3E 6A5
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SudburySAO.moh@ontario.ca

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 79/10 s. 54 (b) O. Reg. 246/22 s. 59 (b)

The licensee shall:

1. Complete a documented review of the resident's interventions to manage exhibited responsive behaviours and the effectiveness of the intervention.
2. Develop and implement an auditing system to ensure that the interventions are implemented as per the resident's plan of care. A copy of these audits must be kept in the home that is accurate and complete for at least one month post the compliance due date to ensure sustainability.
3. Implement and evaluate any corrective actions required to address any identified deficiencies during the audits while ensuring that corrections are incorporated into the quality improvement processes of the home and that these improvements are documented.

Grounds

Non-compliance with O. Reg. 79/10 s. 54 (b) and O. Reg. 246/22 s. 59 (b)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying, and implementing interventions for a resident.

(a) A CIS report was submitted for an altercation that occurred between two residents. At the time of the incident, the one resident was to have a specified intervention in place; however, the intervention had not been implemented when the incident occurred.

A progress note described another incident in which the resident had an altercation with another resident, which resulted in a minor injury to the resident. The CIS report verified that the incident was unwitnessed; however, video footage confirmed that the resident had been the aggressor.

(b) Progress notes identified that on a different date, the resident had an altercation with another resident, which resulted in minor injuries to both residents. An additional progress note identified that the specified intervention had not been in place at the time of the incident.

A Physician's order had indicated that the resident was to have the specified intervention in place at all times.

PSW and Registered staff verified that the resident was to have the specified intervention in place at the time of both incidents, due to their history of responsive behaviours. The CM and

the DOC both verified that the specified intervention was to have been in place to prevent further incidents.

Sources: Three CIS reports; a resident's progress notes and Physician's orders, interviews with direct care staff, registered staff, the CM, and the DOC. [690]

This order is to be complied by September 30, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.