Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2012_104196_0026
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Aug 22, 23, 24, 31, Oct 16, 19, 21, 22, 23, 2012
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX 3251, 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 :	PAULINA CHOW

To ST. JOSEPH'S CARE GROUP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 # / Ordre no : 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. 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 shall ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. LTCHA 2007, S.O.2007,c. 8, s. 19 (1).

Grounds / Motifs :

1. A Critical Incident was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in July 2012 outlining an incident of neglect from a staff member towards a resident. The incident had occurred in July 2012, during the night shift, when resident #003 was found by another staff member to be in their day clothing, in the incorrect incontinence brief, urine and feces on the bed linens and the resident was extremely saturated with urine. The home determined the resident had suffered neglect as a result of not being given appropriate care by staff members #S107 and #S108 on during an evening shift in July 2012, specifically not being changed into their night clothes or having the correct brief applied. Both staff members resigned their positions voluntarily in August 2012.

Staff member #S107 had previously been identified in a Critical Incident report submitted to the MOHLTC in November 2011 for an incident of abuse/neglect towards resident #003 in which the staff member had used excessive force during a transfer. An inspection was subsequently conducted and non-compliance was identified in relation to reporting certain matters to the Director.

Staff member #S107 was again identified in another Critical Incident report submitted to the MOHLTC in April 2012 for an incident in which the employee neglected to provide care for a resident as specified in the resident's plan of care. An inspection was conducted and non-compliance was identified relating to staff member #S107 not following a resident's plan of care.

The licensee was aware of incidents of abuse and or neglect of residents by staff member #S107 dating back to November 2011 and failed to ensure residents were protected.

The licensee failed to protect residents from abuse by anyone and failed to ensure that residents are not neglected by the licensee or staff. [LTCHA 2007,S.O.2007, c. 8, s. 19 (1).] (196)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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 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:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

Ontario

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Order(s) of the Inspector
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Ministére de la Santé et des Soins de longue durée

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch ırmité
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch conformité
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of October, 2012

Signature of Inspector / Signature de l'inspecteur : Lauren Tenhunen #196.

Name of Inspector / Nom de l'inspecteur : Lauren Tenhunen

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of inspection/Genre d'inspection
Aug 22, 23, 24, 31, Oct 16, 19, 21, 22, 23, 2012	2012_104196_0026	Critical Incident

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251, 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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Human Resources Representative, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI Coordinator, Residents

During the course of the inspection, the inspector(s) conducted a tour of all resident care areas, observed the provision of care and services to residents of the home, reviewed the health care records of various residents, reviewed various home policies and procedures, reviewed employee records, reviewed the Critical Incident reports submitted to the Ministry of Health and Long-Term Care (MOHLTC)

Ministry of Health and Long-Term Care (MOHLTC) Log #'s: S-000920-12,S-000898-12

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Critical Incident Response

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

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. A Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in July 2012 outlining an incident of neglect from a staff member towards a resident. The incident had occurred in July 2012, during the night shift, when resident #003 was found by another staff member to be in their day clothing, in the incorrect incontinence brief, urine and feces on the bed linens and the resident was extremely saturated with urine. The home determined the resident had suffered neglect as a result of not being given appropriate care by staff members #S107 and #S108 on an evening shift in July 2012, specifically not being changed into their night clothes or having the correct brief applied. Both staff members resigned their positions voluntarily in August 2012.

Staff member #S107 had previously been identified in a Critical Incident report submitted to the MOHLTC in November 2011 for an incident of abuse/neglect towards resident #003 in which the staff member had used excessive force during a transfer. An inspection was subsequently conducted and non-compliance was identified in relation to reporting certain matters to the Director.

Staff member #S107 was again identified in a Critical Incident report submitted to the MOHLTC in April 2012 for an incident in which the employee neglected to provide care for a resident as specified in the resident's plan of care. An inspection was conducted and non-compliance was identified relating to staff member #S107 not following a resident's plan of care.

The licensee was aware of incidents of abuse and or neglect of residents by staff member #S107 dating back to November 2011 and failed to ensure residents were protected.

The licensee failed to protect residents from abuse by anyone and failed to ensure that residents are not neglected by the licensee or staff. [LTCHA 2007,S.O.2007, c. 8, s. 19 (1).]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. A Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in June 2012 outlining an alleged sexual relationship between resident #001 and a staff member. The home had conducted an investigation and concluded there was no evidence to substantiate that a sexual encounter had occurred between the resident and the staff member. Inspector conducted an interview with staff member #S101 on August 24, 2012 and it was reported that on the night shift, "two staff are always to go into this resident's room to do the hourly checks if there is a male staff working, hence no male staff goes to check on the resident alone during the night". According to staff member #S100, "male staff are wary of the resident and try to get the female staff to provide the care, although there is nothing in writing to state this". The resident's plan of care was reviewed and it did not specify whether or not male staff could or should provide care to this resident or that if a male staff is working on the night shift they are not to check on resident #001 alone.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [LTCHA 2007,S.O.2007, c. 8, s. 6 (1)(c)]
2. A Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in June 2012 outlining an alleged sexual relationship between resident #001 and a staff member. The home had conducted an investigation and concluded there was no evidence to substantiate a sexual encounter had occurred between the resident and the staff member. On August 24, 2012, the inspector and staff member #S100 reviewed resident #001's current care plan with a print date of May 31, 2012 and noted there were no changes or revisions made to the plan since the alleged incident. Despite the resident exhibiting responsive behaviours, specifically the resident's allegation of a sexual relationship with a staff member, the licensee did not ensure that the plan of care was reviewed and revised when the resident's care needs had changed.

The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary; [LTCHA 2007,S.O.2007,c.8,s.6.(10)(b).]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, 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 subsections:

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 or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Director was notified of an incident of neglect towards resident #003 in July 2012, by telephone message and by the licensee's submission of a Critical Incident report. The report identified the incident as occurring in July 2012 on a night shift, when resident #003 was found by staff member #S106, to be in day clothes, incontinent of urine and feces onto the bed linens and wearing the incorrect incontinence brief. This same staff member #S106 told the inspector during an interview on August 23, 2012, that they had sent an email to management to report the concerns they had encountered on the night shift and also verbally told staff member #S100 on the telephone later the same day, that they "felt (resident #003) was not cared for properly and neglected" by staff. An interview was conducted with staff member #S100 on August 23, 2012 and it was confirmed that the incident which had occurred in July 2012 was not reported to the Director until seven days later, after the home had completed their investigation.

A person who has reasonable grounds to suspect that any of the following has occurred or may occur failed to immediately report the suspicion and the information upon which it is based to the Director: 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. [LTCHA 2007,S.O.2007,c.8,s.24.(1)2.]

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 persons who have reasonable grounds to suspect 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 immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 23rd day of October, 2012

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

Lauren Lehmann #196.