Ontario

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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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	Public Copy/Copie Public	
Date(s) of inspection/Date de l'inspection **November 1 – 4, 2010**	**Inspection No/ d'inspection** *2010_106_2923_01Nov144546*	**Type of Inspection/Genre d'inspection** **Mandatory Report Inspection** **Log# S-00499**
Licensee/Titulaire St. Joseph's Care Group, 35 North Algoma Street, P.O. Box 3251, Thunder Bay, ON, P7B 5G7 Fax: 807-345-4994		
Long-Term Care Home/Foyer de soins de longue durée Hogarth Riverview Manor, 300 Lillie Street, Thunder Bay, ON, P7C 4Y7 Fax : 807-623-4520		
Name of Inspector(s)/Nom de l'inspecteur(s) Margot Burns-Prouty #106		
Inspection Summary/Sommaire d'inspection		

The purpose of this inspection was to conduct two inspections concurrently, a complaint inspection and a mandatory report inspection.

During the course of the inspections, the inspector spoke with:

- the Administrator,
- the Director of Care (DOC),
- Human Recourses Personnel,
- Recreation Coordinator
- Registered Practical Nurses,
- Health Care Aids (HCA),
- Dietary Aids,
- Housekeeping Staff,
- Substitute Decision Makers (SDM).

During the course of the inspections, the inspector:

- Conducted a walk-through of all resident home areas and various common areas,
- observed care provided to residents in the facility,
- audited electronic plan of care,
- audited written plan of care,
- reviewed the following:
    - Abuse policies
    - Complaint policies

The following Inspection Protocols were used in part or in whole during this inspection:

- Personal Support Services
- Responsive Behaviours
- Prevention of Abuse and Neglect

Findings of Non-Compliance were found during this inspection. The following action was taken:

7 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S. O. 2007, c. 8, s. 20(2)(b):
At a minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall clearly set out what constitutes abuse and neglect.

Findings:

1. A review of the home's policies on abuse was conducted. No definition or guidance as to what constitutes abuse was found within these polices. The licensee failed to ensure their policies clearly state what constitutes abuse and neglect.

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S. O. 2007, c. 8, s. 20(2)(c):
At a minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall provide for a program, that complies with the regulations, for preventing abuse and neglect.

Findings:

1. A review of the home's policies on abuse was conducted. A program for preventing abuse and neglect was not found. The licensee failed to ensure their policies provide a program for preventing abuse and neglect.

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WN #3: The Licensee has failed to comply with LTCHA, 2007, S. O. 2007, c. 8, s. 24(1)2:
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: 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.

Findings:

1. In a letter dated June 24, 2010 the informant states that in 2009 a staff member was excessively rough while delivering care to a resident. The home had knowledge of this letter prior to and on July 1, 2010 but did not report this to the director until October 5, 2010. The licensee failed to report a suspected incident of abuse of a resident resulting in harm or risk of harm immediately to the director.

2. In a letter dated June 24, 2010 the informant states a staff member yelled at a resident and told them if they did not talk to her nicely they would go back to their room and they would not get breakfast. The home had knowledge of this letter prior to and on July 1, 2010 but did not report this to the director until October 5, 2010. The licensee failed to report an incident of abuse of a resident resulting in harm or risk of harm immediately to the director.

3. In a letter dated June 24, 2010 the informant states that a staff member told a resident they were stupid and threw an item belonging to the resident into the garbage. The home had knowledge of this letter prior to and on July 1, 2010 but did not report this to the director until October 5, 2010. The licensee failed to report a suspected incident of abuse of a resident resulting in harm or risk of harm immediately to the director

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WN #4: The Licensee has failed to comply with O. Reg. 79/10, s. 104(3):
If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

Findings:

1. On or around June 24, 2010, the licensee received a letter dated June 24, 2010 from an informant, in which they made allegations of abuse and neglect by multiple staff members to multiple residents. As of July 10, 2010 the licensee had not submitted a preliminary report to the director and did not submit any report to the director until October 6, 2010. The licensee failed to submit a preliminary report to the Director within 10 days if not everything required under subsection (1) can be provided in a report within 10 days.

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WN #5: The Licensee has failed to comply with O. Reg. 79/10, s. 17(1)(a):
Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times

Findings:

1. On November 1, 2010, 7 residents were observed not to have access to their call bells.

2. On November 4, 2010, 3 residents were observed not to have access to their call bells.

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WN #6: The Licensee has failed to comply with O. Reg. 79/10, s. 96(c):
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, identifies measures and strategies to prevent abuse and neglect.

Findings:

1. A review of the homes policies on abuse that were provided by the home was conducted. The policies did not identify measures and strategies to prevent abuse and neglect. The licensee failed to ensure that their written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents identifies measures and strategies to prevent abuse and neglect.

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WN #7: The Licensee has failed to comply with O. Reg. 79/10, s. 97(1)(b):
Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Findings:

1. The substitute decision maker for a resident was not notified within 12 hours of the home becoming aware of the allegations of abuse to the resident. The home received a letter dated June 24, 2010, on or around that date, that stated a staff member had verbally abused the resident. The home did not report this to the SDM until October 5 or 6, 2010. The licensee failed to notify the resident's SDM within 12 hours of becoming aware of any alleged abuse to the resident.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report (if different from date(s) of inspection).** January 26, 2011