Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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 #/ Registre no	Type of Inspection / Genre d'inspection
Jun 30, 2016;	2016_246196_0006 (A1)	007227-16	Follow up

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) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for Order #001 was extended to June 30, 2016, at the request of the Licensee.

Issued on this 30 day of June 2016 (A1)

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

LAUREN TENHUNEN (196) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 17, 18, 19, 20, 21, 24, 29, 30, 31, April 1, 2016

During the course of the inspection, a walk through of resident home areas was conducted, interactions between staff members and residents were observed, the provision of care and services to residents were observed, the health care records for several residents and various home policies and procedures were reviewed and reviewed home's incident reports.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Regional Behavioural Services, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Manager of Employee Relations, Residents and Family Members.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Training and Orientation

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 6. (1)	CO #001	2015_435621_0012	196
LTCHA, 2007 s. 6. (10)	CO #003	2015_435621_0012	196

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	Legendé 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. 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 failed to ensure that, 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.

As per the O.Reg.79/10, "physical abuse" is defined as "the use of physical force by a resident that causes physical injury to another resident".

The licensee's procedure titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect – LTC – 5-51" last revised February 2016, was reviewed. It identified that all employees are required to report any incident or alleged incident of resident abuse immediately to their Manager/designate. In addition, the procedure identified that the Director/designate and /or VP Seniors' Health must be notified immediately and they would notify the Ministry by phone and the initiation of the Mandatory CIS (Critical Incident System) report. In addition, the procedure indicated that "all incidents of physical abuse that cause physical injury and non-consensual sexual behaviour must be reported to the police and/or MOHLTC".

On a particular day in March 2016, the progress notes of resident #010 were reviewed by Inspector #196 regarding incidents of abuse.

An incident of physical abuse was documented on a specific day in January 2016, by RPN #146, which identified that resident #010 was physically injured by the actions of another resident. The incident was recorded by the hall camera and showed that resident #010 was physically injured by resident #013.

An interview was conducted with Manager #135 by the Inspector and they reported that this incident was not reported to the Director. In addition, they reported that an internal incident report had been completed and they would have been made aware of this incident.

The Inspector reviewed the home's electronic client safety report that was provided by Manager #135. The report was completed by RPN #146, and outlined the incident as it had been documented in the progress notes and identified physical injury and the incident type "abuse/assault (physical) - victim".

RPN #146 and Manager #135 were both aware of the physical abuse incident resulting in injury of resident #010. This did not comply with the licensee's procedure titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect – LTC – 5-51", specifically, the incident was not reported to the MOHLTC (Ministry of Health and Long-Term Care). [s. 24. (1)]

2. During the inspection in March 2016, the progress notes of resident #014 were reviewed and an incident of physical abuse was documented on a specific day in January 2016, by RN #138, which resulted in physical injury. The note also indicated that a message had been left with the manager regarding the incident.

The note indicated that resident #014 was a "victim of physical aggression" when struck by resident #017 which resulted in physical injury to their face.

An interview was conducted with Manager #135 and they reported that this incident was not reported to the Director. The Inspector reviewed the home's electronic client safety report that was provided by Manager #135. The report was completed by RN #138, and outlined the incident as it had been documented in the progress notes and identified physical injury and the incident type "abuse/assault (physical) -

victim".

RN #138 and Manager #135 were aware of the physical abuse incident resulting in injury of resident #014. This did not comply with the licensee's procedure titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect – LTC – 5-51", specifically, the incident was not reported to the MOHLTC. [s. 24. (1) 2.]

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:CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 resident #005 as specified in the plan.

The health care records for resident #005 were reviewed. The physician's orders on a specific day in March 2016 included a request to fill out specific documentation X 1 week, and off to the side of the order it identified the date and time that it was started.

On March 31, 2016, the specific documentation for resident #005 was reviewed for information. Numerous areas did not contain information during the course of the one week documentation period.

On March 31, 2016, an interview was conducted with Manager #135 and they confirmed that the specific documentation was a tool used to assess a resident and confirmed that it was not completed in entirety for resident #005 as ordered. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #011 as specified in the plan.

The health care records for resident #011 were reviewed. The physician's orders on a specific day in March 2016 included a request to fill out specific documentation X 1 week, and off to the side of the order it identified the date and time that it was started.

On March 31, 2016, the specific documentation for resident #011 was reviewed for information. Numerous areas did not contain information during the course of the one week documentation period.

On March 31, 2016, an interview was conducted with Manager #135 and they confirmed that the specific documentation was a tool used to assess a resident and confirmed that it was not completed in entirety for resident #011 as ordered. [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 that the care set out in the plan of care is provided to resident #005 and resident #011 as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

The progress notes for resident #012 were reviewed by the Inspector and four incidents of suspected sexual abuse were documented over an eighteen day period in 2016.

The first incident occurred on a specific date and there was a note documented by Recreation Staff #144, which read "Victim of inappropriate behaviour" which identified resident #012 as having been touched sexually by co-resident # 015. The note went on and included resident #012's response to the occurrence.

The second incident occurred on another date and there was a note documented by RN #145, which read "Claims of Sexually Inappropriate Behaviour" and identified resident #012's claim that resident #016 had tried to sexually touch them and that they didn't like that resident in their room.

The third incident occurred on another date and there was a note documented by RN #145, which read "Victim of Sexually Inappropriate Behaviour" and identified resident #015 had been witnessed to attempt to sexually touch resident #012. The note went on and indicated that resident #012 was trying to cover themselves up to prevent the co-resident from sexually touch them.

The fourth incident occurred on another date and there was a note documented by RN #145, which read "Victim of Sexually Inappropriate Behaviour" and identified that resident #012 was witnessed to be sexually touched by resident # 015.

During the inspection, an interview with RN #109 was conducted regarding the documented progress notes which outlined incidents of suspected sexual abuse towards resident #012. They reported that they had not completed internal incident reports for the incidents that they were aware of, between resident #015 and resident #012. They reported that the SDM (Substitute Decision Maker) of either resident were not notified of the occurrences.

During the inspection, an interview was conducted with Manager #135 regarding the incidents as documented in resident #012's progress notes. They reported that internal incident reports had not been completed for these sexual behaviour incidents, they were unaware of these incidents and investigations were not conducted.

The licensee's procedure titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect – LTC – 5-51" last revised February 2016, was reviewed. It identified that all employees are required to report any incident or alleged incident of resident abuse immediately to their Manager/designate. In addition, the procedure identified that the Director/designate and /or VP Seniors' Health must be notified immediately so that an investigation is initiated and they would notify the Ministry by phone and the initiation of the Mandatory CIS (Critical Incident System) report. In addition, the procedure indicated that "all incidents of physical abuse that cause physical injury and non-consensual sexual behaviour must be reported to the police and/or MOHLTC".

The staff members that were aware of the four suspected sexual abuse incidents towards resident #012 did not comply with the licensee's procedure titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about

Incidents of Abuse or Neglect – LTC – 5-51". Specifically, the incidents were not immediately reported to their Manager or designate, the incidents were not investigated and therefore were not reported to the MOHLTC by phone or by the Critical Incident System. [s. 20. (1)]

2. During an interview with RN #138 on a day during the inspection, the Inspector observed, on the nursing desk, the RN shift report from the night shift which read "(resident #005) sexually touching another resident on evenings". When asked about the incident, they reported that it had been communicated to the manager via email and put in the physician's book.

The health care records for resident #005 were reviewed for information regarding responsive behaviours.

On a particular day in March 2016, there was a progress note documented by RPN #147 which identified an incident in which staff observed resident #005 touch co-resident #011 in a sexual manner. The details of the observations were noted in the progress notes.

The documents outlining the plan of care, specifically the current care plan and the 24 hour LTC plan of care, were reviewed and did not contain information regarding responsive behaviours.

On a specific day during the inspection, the Administrator and Manager #135 approached the Inspector and reported that an investigation was conducted today, nine days after the incident. They went on to say that they had spoken with the staff members and that the incident was not as severe as it was recorded in the progress notes. In addition, the Administrator stated that these types of behaviours happen on this particular unit and that is why residents are there. They both questioned whether the incident needed to be reported to the Ministry as it was felt that no harm or risk of harm had occurred and they had looked at the abuse decision tree for guidance.

The staff member that was aware of the suspected sexual abuse incidents towards resident #011 did not comply with the licensee's procedure titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect – LTC – 5-51". Specifically, the incidents were not immediately reported to their Manager or designate, the incidents were not investigated and therefore were not reported to the MOHLTC by phone or by the Critical Incident

System. [s. 20. (1)]

3. During the inspection, an interview was conducted with RN #138 on one of the resident home areas. They reported that there had been a couple of incidents in which resident #010 was sexually abused by resident #009 and denied that there was a relationship with these residents.

The health care records of resident #010 were reviewed for information regarding responsive behaviours.

On a specific day in February 2016, there was a progress note documented by RPN #148, which identified an incident in which resident #010 was witnessed to be sexually touched by resident #009 while in the dining room.

On a specific day in March 2016, there was a progress note documented by RN #138, which identified an incident in which resident #010 was "inappropriately touched", sexually, by resident #009.

The care plan for resident #010 identified that the presence of behaviours, including sexual behaviours towards staff and or co-residents. The care plan for resident #009 identified a "history of sexually inappropriate behaviour (touching co-residents and staff)".

During the inspection, an interview was conducted with Manager #135. They reported that they were not aware of the incidents documented on the specific days in February and March 2016, involving resident #010 and resident #009. They also reported that they were aware that resident #009 had tendencies to reach out.

The staff members that were aware of the suspected sexual abuse incidents towards resident #010 did not comply with the licensee's procedure titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect – LTC – 5-51". Specifically, the incidents were not immediately reported to their Manager or designate, the incidents were not investigated and therefore were not reported to the MOHLTC by phone or by the Critical Incident System. [s. 20. (1)]

4. An interview was conducted with RN #138 during the inspection, and they reported that resident #009 had responsive behaviours towards co-residents in the home.

The health care records for resident #009 were reviewed for information regarding responsive behaviours.

The progress notes for resident #009 documented incidents of responsive behaviours towards co-residents over an approximate two month period in 2016. In addition, on a specific day in January 2016, the attending physician documented a note which identified the reason for admission included responsive behaviours.

On a specific date there was a progress note documented by PSW #140 which outlined an incident in which resident #009 was observed to sexually touch resident #018's. In addition, the note went on to report that the resident then approached resident #019 and started to touch them.

On another date there was a progress note documented by Recreation Therapist #144 which outlined an incident in which resident #009 had displayed "sexually inappropriate behaviour" and sexually touched resident #019.

On another date there was a progress note documented by RPN #148 which outlined an incident in which resident #009 was observed to sexually touch resident #010.

On another dated there was a progress note documented by RN #138 which outlined an incident in which resident #009 was witnessed to sexually touch another resident.

On another dated there was a progress note documented by RN #109 which outlined an incident in which resident #010 was witnessed to sexually touch a co-resident.

On another date there was a progress note documented by RPN #149 which outlined an incident in which resident #009 was "Sexually Inappropriate" and had sexually touched a co-resident.

An interview was conducted with Manager #135, and they reported that they were not aware of these incidents, and had not received any internal incident reports regarding any sexual behaviours of residents in the resident home area they manage. In addition, an investigation had not been conducted in relation to these incidents.

The staff members that were aware of the sexual behaviour incidents towards other residents did not comply with the licensee's procedure titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect – LTC – 5-51". Specifically, the incidents were not immediately reported to their Manager or designate and the incidents were not investigated. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

During the inspection, the Inspector became aware of an incident in which resident #005 displayed responsive behaviours on a specific date.

The health care records for resident #005 were reviewed for information regarding responsive behaviours. The LTC 24 Hour Care Plan dated on admission did not reference responsive behaviours. The care plan in resident's paper chart with print date of the day after admission to the home and copy as found online in med-e-care approximate one week later did not identify socially inappropriate behaviours or responsive behaviours. The progress notes on admission noted "please monitor interactions with (opposite gender) co-residents". The "Admission Assessment" identified that resident #005 was socially inappropriate and "likes the (opposite gender)" - targets confused (opposite gender)."

During the inspection, PSW #141 and PSW #142 were interviewed regarding the behaviours of resident #005. Neither PSW identified knowledge of responsive behaviours of this resident and PSW # 141 reported that for information about a resident they would look at the care plan. [s. 26. (3) 5.]

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 plan of care of resident #005 is based on, at a minimum, an interdisciplinary assessment of the following with respect to the resident: Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible.

On a particular day during the inspection, the Inspector observed, the RN report on the nursing desk, from the early night shift, which noted "(resident #005) responsive behaviours towards another resident on evenings".

The health care records for resident #005 were reviewed for information regarding responsive behaviours.

A progress note dated nine days after admission to the home, identified an incident in which responsive behaviours were displayed with another co-resident and a detailed description was noted.

The LTC 24 Hour Care Plan dated from admission was reviewed and there was no reference to responsive behaviours. The current care plan as found in the paper chart and online did not include reference to responsive behaviours.

The "Admission Assessment" identified that the resident "likes the (opposite gender)" - targets confused (opposite gender)". The Behavioural Assessment Tool with faxed to the home prior to admission, noted "touches others inappropriately" and hand written "likes the (opposite gender) - seems to gravitate towards the very confused (opposite gender) - target of opportunity".

During the inspection, an interview was conducted with PSW #141 and PSW #142 and they reported that resident #005 was a new resident to the resident home area and they were unaware of responsive behaviours when asked. PSW #141 went on to report that for information about a resident they would look at the care plan. [s. 53. (4) (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 that ensures that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Administrator worked regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week.

During the inspection in March 2016, an interview was conducted with the Administrator of the home. They reported that they were the Administrator for both the Hogarth Riverview Manor and Bethammi long-term care home sites. In addition, they confirmed with the Inspector that they split their time between the two long-term care homes and are not working regularly as the Administrator in this home for 35 hours per week. They also reported it would be "hard to do and would have to have funding for this".

On March 30, 2016, a telephone interview was conducted with the Manager of Employee Relations. They reported that the staff identified as the home's Administrator had the job title of " Vice President of Seniors' Health and Chief Nursing Officer" and served as the Chief Nursing Officer (CNO) for the organization, including the hospital site and the Lakehead Psychiatric Hospital (LPH) site. When asked by the Inspector to provide the hours that the Administrator worked in each role, they were unable to specify. [s. 212. (1) 3.]

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 home's Administrator works regularly in that position on site at the home for at least 35 hours per week, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

During the inspection in March 2016, the President and CEO of the licensee reported to the Inspector that Director of Care (DOC) #101 no longer worked at the home and Administrator #100 would be the interim DOC.

An interview was then conducted with the Administrator and they confirmed their new position as acting DOC at Hogarth Riverview Manor, which had over 370 beds. In addition, they reported that they were currently the Administrator for both the Hogarth Riverview Manor and Bethammi Nursing Home long-term care home sites. [s. 213. (1) 5.]

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 home's Director of Nursing and Personal Care works regularly in that position on site at the home at least 35 hours per week, to be implemented voluntarily.

Issued on this 30 day of June 2016 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

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Téléphone: (705) 564-3130
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196) - (A1)
Inspection No. / No de l'inspection :	2016_246196_0006 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / Registre no. :	007227-16 (A1)
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 30, 2016;(A1)
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 :	Meaghan Sharp

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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 # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_435621_0012, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007, 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, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall:

a) ensure that a person who has reasonable grounds to suspect that 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 reports the suspicion and the information upon which it is based to the Director.

b) provide training and re-training for all staff related to the mandatory reporting of abuse of a resident that resulted in harm or a risk of harm to the resident.

c) maintain records of the contents of the training, the names of the attendees, the names of the educators and the dates of the training.

Grounds / Motifs :

1. The licensee failed to ensure that, 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.

As per the O.Reg.79/10, "physical abuse" is defined as "the use of physical force by a resident that causes physical injury to another resident".

The licensee's procedure titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect – LTC – 5-51" last revised February 2016, was reviewed. It identified that all employees are required to report any incident or alleged incident of resident abuse immediately to their Manager/designate. In addition, the procedure identified that the Director/designate and /or VP Seniors' Health must be notified immediately and they would notify the Ministry by phone and the initiation of the Mandatory CIS (Critical Incident System) report. In addition, the procedure indicated that "all incidents of physical abuse that cause physical injury and non-consensual sexual behaviour must be reported to the police and/or MOHLTC".

On a particular day in March 2016, the progress notes of resident #010 were reviewed by Inspector #196 regarding incidents of abuse.

An incident of physical abuse was documented on a specific day in January 2016, by RPN #146, which identified that resident #010 was physically injured by the actions of another resident. The incident was recorded by the hall camera and showed that resident #010 was physically injured by resident #013.

An interview was conducted with Manager #135 by the Inspector and they reported that this incident was not reported to the MOHLTC Director. In addition, Manager #135 reported that a internal incident report had been completed and they would have had been made aware of this incident.

The Inspector reviewed the home's electronic client safety report that was provided by Manager #135. The report was completed by RPN #146, and outlined the

incident as it had been documented in the progress notes and identified physical injury and the incident type "abuse/assault (physical) - victim".

RPN #146 and Manager #135 were both aware of the physical abuse incident resulting in injury of resident #010. This did not comply with the licensee's procedure titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect – LTC – 5-51", specifically, the incident was not reported to the MOHLTC. (196)

2. During the inspection in March 2016, the progress notes of resident #014 were reviewed and an incident of physical abuse was documented on a specific day in January 2016, by RN #138, which resulted in physical injury. The note also indicated that a message had been left with the manager regarding the incident.

The note indicted that resident #014 was a “victim of physical aggression” when struck by resident #017 which resulted in physical injury to their face.

An interview was conducted with Manager #135 and they reported that this incident was not reported to the Director. The Inspector reviewed the home's electronic client safety report that was provided by Manager #135. The report was completed by RN #138, and outlined the incident as it had been documented in the progress notes and identified physical injury and the incident type "abuse/assault (physical) - victim".

RN #138 and Manager #135 were aware of the physical abuse incident resulting in injury of resident #014. This did not comply with the licensee's procedure titled “Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect – LTC – 5-51”, specifically, the incident was not reported to the MOHLTC.

Non-compliance related to this legislation was issued February 16, 2016 - Compliance Order - inspection # 2015_435621_0012, October 29, 2015 - Compliance Order - inspection # 2015_333577_0012, September 2, 2014 - Written Notification and Voluntary Plan of Correction - inspection # 2014_246191_0016.

The decision to re-issue this Compliance Order was based on the scope which affected two residents, the severity which indicates minimum harm or potential for actual harm and the compliance history. Despite the issuance of two compliance orders and a WN/VPC in past three years, the licensee continues to be in non compliant with s.24.(1) of the LTCHA.

(196)

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

Jun 30, 2016(A1)

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
Long-Term Care Inspections Branch
Ministry of Health and 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 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 Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 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:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 30 day of June 2016 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LAUREN TENHUNEN - (A1)

Service Area Office / Bureau régional de services : Sudbury