Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 7, 2020	2020_655679_0003	019959-19, 020076-19, 020311-19, 020326-19, 020327-19, 020388-19, 020478-19, 020906-19, 021815-19, 022304-19, 022777-19	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street THUNDER BAY ON P7B 5G7

Long-Term Care Home/Foyer de soins de longue durée

Hogarth Riverview Manor
300 Lillie Street THUNDER BAY ON P7C 4Y7

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

MICHELLE BERARDI (679), AMANDA BELANGER (736), AMY PAGE (749), JENNIFER NICHOLLS (691), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 27-31, 2020.

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:

- Three intakes submitted to the Director for allegations of staff to resident abuse;
- One intake submitted to the Director for an incident of resident to resident abuse;
- One intake submitted to the Director related to a resident fall with injury;
- Three intakes submitted to the Director for improper or incompetent care; and,
- Three intakes submitted to the Director for visitor to resident abuse.

A Complaint Inspection (2019_655679_0004) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers (CM), Registered Dietitian (RDs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapy Assistants (PTAs), Resident Home Workers (RHWs), Food Service Workers (FSWs), residents and families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, complaint records, as well as relevant policies and procedures.

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

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

7 WN(s)
4 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 was protected from abuse by anyone.

A Critical Incident (CI) report was submitted to the Director, which indicated that resident #004 was alleged to have been abused by Personal Support Worker (PSW) #133 on a specified date. The report further indicated that PSW #134 reported the allegation of abuse to Registered Practical Nurse (RPN) #139. RPN #139 assessed resident #004 post incident and noted a specified injury.

Inspector #691 reviewed the home's investigation notes which contained interviews from staff on shift during the time of the incident. The Inspector reviewed separate interviews by Clinical Manager (CM) #119, PSW #146, PSW #124 and PSW #134. In each interview, the staff identified that on a specified date, resident #004 was exhibiting responsive behaviors during care towards PSW #133. The interview notes from PSW #123, PSW #146 and PSW #134 further indicated the allegation of abuse.

Inspector #691 further reviewed the investigation notes between PSW #133 and CM #119. The interview notes identified that PSW #133 indicated that they were performing care on resident #004 on a specified date. PSW #133 indicated that resident #004 was exhibiting responsive behaviors and identified that they performed a specified action, in order to provide care. PSW #133 further indicated that they identified a specified injury to resident #004 post incident. The investigation records also identified a letter addressed from the home to PSW #133, which detailed the incident, and identified that PSW #133 was to complete retraining in "Zero Tolerance for Neglect and Abuse".

Inspector #691 reviewed resident #004's progress notes for the date of the incident, which indicated that RPN #134 identified resident #004 had a specified injury after PSW

#134 completed care.

Inspector #691 reviewed resident #004's care plan that was current at the time of the incident, which indicated a specified intervention for the management of resident #004's responsive behaviours.

During an interview with PSW #134, they indicated to Inspector #691 that they were working on the specified date with PSW #133, and identified the incident. PSW #134 also indicated that they had observed the specified injury to resident #004.

A review of the homes policy titled "Extendicare- Zero Tolerance of Resident Abuse and Neglect Program", last updated June 2019, identified that Extendicare has zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, will not be tolerated.

During an interview with CM #116, they confirmed to Inspector #691, that at the time of the incident, PSW #133 performed a specified action while providing care to resident #004. CM #116 further identified that as a consequence, the home failed to comply with their Zero Tolerance of Resident Abuse and Neglect policy. [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:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 based on an assessment of the resident and the needs and preferences of that resident.

A CI report was submitted to the Director for an incident of improper or incompetent treatment of a resident that resulted in harm or risk of harm to a resident. The CI report indicated that resident #008 did not receive their specified nutritional care intervention. See WN #3 for further details.

A review of the CI report identified that resident #008 had a specified document within their medical records related to their nutritional care intervention.

Inspector #679 reviewed resident #008's care plan which referenced the specified document which was on file related to their nutritional care intervention.

Inspector #679 reviewed the specified document, and identified it was signed by the resident, CM and physician.

Inspector #679 reviewed resident #008's electronic records and identified that they had a specific level of cognition.

Inspector #679 reviewed resident #008's electronic progress notes and identified a note written by Speech Language Pathologist (SLP) #145 which indicated that the resident was unable to make decisions regarding their care.

In an interview with RPN #121, they indicated that resident #008 was not capable to make decisions regarding their care.

In an interview with CM #119, they indicated that resident #008 signed the specified document related to their nutritional care intervention.

In an interview with Inspector #679, the Director Of Care (DOC) indicated that the specified document was in place regarding resident #008's specified nutritional intervention. The DOC indicated that they did not know why resident #008 had signed the document, because normally the home would get the Substitute Decision Maker (SDM) or the Public Guardian and Trustee (PGT) to sign it. The DOC identified they didn’t think that resident #008 would be capable to make the decision. The DOC then reviewed resident #008’s CPS score from their medical records and indicated that the resident had a specific level of cognition. [s. 6. (2)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #009 as specified in the plan.

A CI report was submitted to the Director for an incident of improper or incompetent treatment of a resident that resulted in harm or a risk of harm to a resident. The CI report identified that a PSW was conducting an audit and noted resident #009 was alone, with a specified transfer intervention in place.

Inspector #679 reviewed resident #009's care plan which was in place at the time of the incident. The care plan outlined the use of a specified transfer device, and identified the need for two staff members to be present when using the transfer device. The care plan further indicated that two staff members were required for a specific type of care.

In an interview with PSW #108, they indicated that they assisted resident #009 alone on the day of the incident. PSW #108 identified that resident #009 required the assistance of two staff members for care.

Inspector #679 reviewed the home's internal investigation notes regarding this incident and identified a handwritten note titled "Video Footage Review", which indicated that PSW #108 was observed entering and exiting resident #009's room alone.

In an interview with RPN #121, they identified that if staff were assisting the resident with a specified type of care, it should be completed by two staff members.

Inspector #679 reviewed a letter which was addressed to PSW #108. The letter indicated that PSW #108 failed to follow the resident's care plan.

In an interview with CM #119, they indicated that staff would reference a resident's care plan to determine the care needs. CM #119 indicated for a specified type of care resident #009 required the assistance of two staff members. [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 ensuring that the plan of care is based on an assessment of the resident and the needs and preferences of that resident, and that the care set out in the plan of care is provided to residents as specified in the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with food and fluids that were safe, adequate in quantity, nutritious and varied.

A CI report was submitted to the Director for an incident of improper or incompetent treatment of a resident that resulted in harm or risk of harm to a resident. The CI report indicated that resident #008 did not receive their specified nutritional care intervention.

Inspector #679 reviewed resident #008's care plan which indicated that the resident required a specified nutritional intervention.

Inspector #679 reviewed the resident's electronic progress notes and identified a note written on the date of the incident, which indicated that the resident was not provided with a specified nutritional intervention.

Inspector #679 reviewed the home's internal investigation notes related to the incident, which included written notes from an interview with a dietary staff member. The interview notes indicated that resident #008 was not provided with their specified nutritional

intervention.

In an interview with Resident Home Worker (RHW) #103, they indicated that resident #008 required a specified nutritional intervention. RHW #103 further indicated that resident #008 did not receive their specified nutritional intervention.

In an interview with RHW #144, they indicated that they had provided resident #008 with an incorrect nutritional intervention.

In an interview with RPN #110, they indicated that staff would reference a resident's care plan or diet sheets to identify a resident's nutritional interventions. RPN #110 indicated that resident #008 required a specified nutritional intervention. RPN #110 indicated that at the time of the incident, they were notified by another RPN that resident #008 was provided an incorrect nutritional intervention.

In an interview with Registered Dietitian (RD) #114, they identified that resident #008 required a specified nutritional intervention. RD #114 further indicated that they had assessed the resident after the incident, and identified that the resident was not provided their specified nutritional intervention. RD #114 confirmed it was the home's expectation that staff follow the nutritional interventions as outlined in a resident's care plan.

In an interview with CM #119, they identified that RHW #144 did not know the resident, that there was mixed communication, and that resident #008 was provided with an incorrect nutritional intervention. CM #119 confirmed that staff were to follow residents care plans. [s. 11. (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 ensuring that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting resident #009.

A CI report was submitted to the Director for an incident of improper or incompetent treatment of a resident that resulted in harm or a risk of harm to a resident. The CI report identified that a PSW was conducting an audit and noted resident #009 was alone, with a specified transfer intervention in place.

In an interview with PSW #143, they identified that they were completing an audit when they observed resident #009 with a specified transfer intervention in place. PSW #143 further indicated that two staff members were to be present at all times when completing the transfer intervention.

Inspector #679 reviewed resident #009's care plan which was in place at the time of the incident. The care plan outlined the use of a specified transfer intervention, and identified the need for two staff members to be present when completing the specified intervention.

In an interview with PSW #108, they indicated that they assisted resident #009 alone on the day of the incident and that they implemented the specified transfer intervention. PSW #108 indicated that resident #009 required a specified transfer intervention with the assistance of two staff members, and that it was wrong to implement the intervention alone.

Inspector #679 reviewed the policy titled Minimal Lift (Client/Resident) [Policy HR 7-221] dated September 17, 2019. The policy identified that the lifting, transferring or repositioning interventions must be used as indicated in the assessment of the client/resident.

In an interview with RPN #121, they identified that resident #009 required a specified

transfer intervention with the assistance of two staff members. RPN #121 identified that when staff were transferring residents, there was to be two staff members present.

Inspector #679 reviewed a letter which was addressed to PSW #108. The letter indicated that PSW #108 failed to follow the resident's care plan and to follow safe transfer practices.

In an interview with CM #119, they indicated that the home conducted specified audits, and that a PSW conducting the audit observed that resident #009 utilizing the specified transfer intervention, and that there were no staff present. CM #119 identified that there needed to be two staff present when implementing the specified transfer intervention. [s. 36.]

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 ensuring that staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirement was met when a resident was being restrained by a physical device under section 31 of the Act: the resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

A CI report was submitted to the Director concerning an allegation of staff to resident #006 neglect by PSW #132 and PSW #137. The CI report identified while staff were providing care for resident #006, they noted resident #006 was in a specified position while a restraint was in use. Both PSW #132 and PSW #137 reported that they had repositioned resident #006, and noted that the resident was in the specified position resulting in injury. It was further identified that RPN #130 had completed an assessment, and noted a specified injury to resident #006.

A review of the home's investigation notes contained an interview by CM #135 with PSW #136. The interview identified that PSW #136 confirmed that they had not performed safety checks for resident #006 hourly, as per the homes policy and resident #006's care plan. Additionally, documentation of the home's video footage from the date of the incident identified that PSW #136 did not perform safety checks on resident #006 for a specified period. The investigation records also identified a letter addressed from the home to PSW #136, which indicated that the PSW did not perform checks on a resident and did not check the specified restraint every hour as per the residents plan of care, with respect to this incident.

Inspector #691 reviewed resident #006's care plan in effect at the time of the incident, which identified the use of a specified restraint. It further identified that staff were to assess the restraint at specified intervals; monitor and assess as per the home's policy. During interviews with PSW #131 and PSW #132, they indicated to Inspector #691 that as per resident #006's care plan, they required a specified restraint. PSW #131 and PSW #132 further indicated that while resident #006 had the restraint in place, the care plan indicated that the resident needed to be monitored at a specified interval.

During an interview with CM #135, they reported to the Inspector that PSW #136 was found on a specified date, to have not provided any restraint monitoring to resident #006 as per their plan of care, and they should have. [s. 110. (2) 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 ensuring that the following requirement is met when a resident is being restrained by a physical device under section 31 of the Act: the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A CI report was submitted to the Director on a specified date, related to alleged abuse towards resident #010.

The Inspector reviewed the home's internal investigation documents, which identified an email dated a specified date that was sent to CM #125 from RPN #118, indicating they suspected abuse towards resident #010.

Inspector #543 reviewed the home's "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" (RC-02-01-02) policy. According to the policy, management was to promptly and objectively report all incidents to external regulatory authorities.

Inspector #543 reviewed the home's "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" (RC-02-01-03) policy. According to the policy, the Administrator or designate was to ensure that reporting requirements to provincial/regulatory bodies had been completed as required.

Inspector #543 interviewed RPN #118 who verified that their understanding of mandatory reporting requirements, was that every form of abuse should be immediately reported to "the Ministry".

The Inspector interviewed CM #125 who indicated that they had spoken to RPN #118 regarding the process for reporting incidents of abuse. They verified that the RPN had sent an email on a specified date; however, the email was not received until the next day. The CM indicated that the manager on call should have been notified in order for it to be immediately reported to the Director. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001, who required continence care products, had sufficient changes to remain clean, dry and comfortable.

A CI report was submitted to the Director regarding a complaint that the home received regarding resident #001's continence care. The CI report indicated that resident #001 had not been provided with continence assistance for a specified period.

Inspector #749 reviewed resident #001’s care plan which identified specified interventions to manage the resident's continence.

A review of the home’s investigation file indicated that resident #001’s family member identified the incident whereby resident #001's continence care was not provided for a specified period.

In an interview with PSW #115, they indicated to Inspector #749 that resident #001 was to be assisted with a continence intervention at specified intervals. PSW #115 went on to say that resident #001's intervention was forgotten on the specified date.

In an interview PSW #124, who was responsible for resident #001’s personal care, they indicated to Inspector #749 that they did not mean to forget to implement resident #001's continence intervention.

Inspector #749 interviewed CM #125 who confirmed that resident #001 was assisted with a specified continence intervention, and that resident #001’s family member discussed the resident’s care with a PSW and had requested that resident #001 be assisted at a specified time. CM #125 also confirmed that at a specified time the resident was brought to the dinning without their continence intervention being implemented. CM #125 indicated that PSW #124 was responsible for resident #001’s care and neglected to assist resident #001 with the specified continence intervention. [s. 51. (2) (g)]

Issued on this 10th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE BERARDI (679), AMANDA BELANGER (736), AMY PAGE (749), JENNIFER NICHOLLS (691), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2020_655679_0003
Log No. / No de registre :	019959-19, 020076-19, 020311-19, 020326-19, 020327-19, 020388-19, 020478-19, 020906-19, 021815-19, 022304-19, 022777-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 7, 2020
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, 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 :	Sheila Clark

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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 Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 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 must be compliant with s. 19. (1) of the Long Term Care Homes Act, 2007.

Specifically, the licensee must ensure that residents of the home are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #004 was protected from abuse by anyone.

A Critical Incident (CI) report was submitted to the Director, which indicated that resident #004 was alleged to have been abused by Personal Support Worker (PSW) #133 on a specified date. The report further indicated that PSW #134 reported the allegation of abuse to Registered Practical Nurse (RPN) #139. RPN #139 assessed resident #004 post incident and noted a specified injury.

Inspector #691 reviewed the home's investigation notes which contained interviews from staff on shift during the time of the incident. The Inspector reviewed separate interviews by Clinical Manager (CM) #119, PSW #146, PSW #124 and PSW #134. In each interview, the staff identified that on a specified date, resident #004 was exhibiting responsive behaviors during care towards PSW #133. The interview notes from PSW #123, PSW #146 and PSW #134 further indicated the allegation of abuse.

Inspector #691 further reviewed the investigation notes between PSW #133 and CM #119. The interview notes identified that PSW #133 indicated that they were

performing care on resident #004 on a specified date. PSW #133 indicated that resident #004 was exhibiting responsive behaviors and identified that they performed a specified action, in order to provide care. PSW #133 further indicated that they identified a specified injury to resident #004 post incident. The investigation records also identified a letter addressed from the home to PSW #133, which detailed the incident, and identified that PSW #133 was to complete retraining in "Zero Tolerance for Neglect and Abuse".

Inspector #691 reviewed resident #004's progress notes for the date of the incident, which indicated that RPN #134 identified resident #004 had a specified injury after PSW #134 completed care.

Inspector #691 reviewed resident #004's care plan that was current at the time of the incident, which indicated a specified intervention for the management of resident #004's responsive behaviours.

During an interview with PSW #134, they indicated to Inspector #691 that they were working on the specified date with PSW #133, and identified the incident. PSW #134 also indicated that they had observed the specified injury to resident #004.

A review of the homes policy titled "Extendicare- Zero Tolerance of Resident Abuse and Neglect Program", last updated June 2019, identified that Extendicare has zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, will not be tolerated.

During an interview with CM #116, they confirmed to Inspector #691, that at the time of the incident, PSW #133 performed a specified action while providing care to resident #004. CM #116 further identified that as a consequence, the home failed to comply with their Zero Tolerance of Resident Abuse and Neglect policy.

The severity of this issue was determined to be a level three, as there was actual harm/actual risk. The scope of the issue was a level one, as the incident was isolated. The home has a level three compliance history with related non-compliance in the last 36 months with this section of the LTCHA.

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

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

- A Written Notification (WN) issued September 2019, during inspection 2019_768693_0021;
- A Compliance Order (CO) issued August, 2019, during inspection #2019_746692_0019;
- A CO issued October 2018, during inspection #2018_624196_0023; and,
- A CO issued October 2017, during inspection #2017_509617_0017;
(679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 25, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
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
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of February, 2020

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Michelle Berardi

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