Ontario

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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Nov 25, 2016;	2016_391603_0022 (A1)	021254-16, 024815-16, 024818-16, 025633-16, 026004-16, 026028-16, 026753-16, 027410-16, 027482-16, 027744-16, 027972-16, 028010-16, 028086-16, 028269-16, 028347-16, 028383-16, 028538-16, 029749-16, 030063-16	Critical Incident System

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

LINDSAY DYRDA (575) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date for CO #001 extended to December 31, 2016.

Issued on this 25 day of November 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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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

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

LINDSAY DYRDA (575) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 11-14, 17-21, 2016.

This Critical Incident Inspection was related to 19 intakes: 13 intakes related to allegations of resident abuse; three intakes related to resident falls; two intakes related to missing narcotics; and one intake related to alleged injury.

A Complaint Inspection #2016_391603_0023 and a Follow Up Inspection #2016_391603_0022 were conducted concurrently. Non-compliance regarding s. 6 (7) found during this Critical Incident Inspection was issued in Follow Up Inspection #2016_391603_0022 .

During the course of the inspection, the inspector(s) directly observed the delivery of resident care, staff to resident interactions, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed various home policies, procedures, and programs, and reviewed staff education attendance records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Client Care Coordinator, Clinical Managers, Resident Assessment Instrument (RAI) Coordinators, Maintenance Supervisor, Environmental Services Supervisors, Staffing Coordinator,

Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Staff, residents, and family members.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Hospitalization and Change in Condition

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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

- **6 WN(s)**
- **3 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	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. 6. Plan of care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #603 reviewed a Critical Incident (CI) Report submitted to the Director, which related to an injury/hospital transfer/significant change in status. According the CI report, resident #021 was found on the floor and the staff assumed it was a fall. Four days before the CI, resident #021 was found sitting on the floor next to their bed. Later that day, resident #021 was observed to be injured, and they were sent to the hospital for x-rays and later returned.

During the inspection, Inspector #603 observed resident #021 sitting in a specific chair.

The Inspector interviewed PSW #140 who was attending resident #021. PSW #140 explained that the resident used a specific chair to ambulate but they were able to get up on their own, transfer independently, but with some difficulty. PSW #140 further explained that staff had to assist and monitor resident #021 closely as they had recent falls, when attempting to ambulate on their own.

The Inspector also interviewed attending RN #139 who explained that the resident had been using a specific chair because they were unsteady on their feet, had tried to get up on their own, and had previously fallen. For these reasons, RN #139 further explained that the resident required closer monitoring.

The Inspector reviewed resident #021's current care plan which identified focuses for "Toileting, Transferring, Bed Mobility, Walk in Room, Walk in Corridor, Locomotion on Unit", and all of these focuses had "independent, no help or oversight needed, or no physical help needed" as part of the interventions. The care plan also had a focus on "Aids to Daily Living" and the intervention indicated that the resident was fully independent without devices. Under the focus of "Falls/Balance", there was no intervention for specific chair requirement or close monitoring. [s. 6. (10) (b)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

Inspector #616 reviewed a CI submitted to the Director, which related to resident to resident abuse on a specific date. The CI detailed how resident #002 pushed the chair where resident #023 was seated, which caused them to fall to the floor. Resident #023 sustained an injury.

The Inspector reviewed resident #002's progress notes related to responsive behaviours with co-residents for a period of three months. Fifteen incidents of resident #002's responsive behaviours were documented.

The Inspector reviewed a progress note from a third party, dated before the CI. It was noted that resident #002 continued to have responsive behaviours with co-residents, but that this resident was easily redirected, as long as there was always a staff member in close proximity to resident #002 when around other residents.

The Inspector reviewed resident #002's care plan effective at the time of the incident and behaviour problems were identified. One of the interventions to prevent or minimize behaviours was to keep co-residents away from resident #002 when displaying responsive behaviours, and to increase monitoring as resident #002 was highly responsive to other residents.

During the Inspector's interview with the Clinical Manager #111, they stated that prior to the physical altercation resulting in resident #023's injury, a four hour "monitor shift" had been implemented from Monday to Sunday from 1600-2000 hours. Further, an additional "monitoring shift" had been initiated Monday through Friday from 0700-1500 hours, above the regularly scheduled PSW staffing complement. Clinical Manager #111 stated that the monitor assignment was in part, an intervention to the increased incidences of responsive behaviours by resident #002 to other residents. They stated as a result of this specific CI report, they had assigned one to one monitoring of resident #002 by a staff member who was responsible only for monitoring and intervening resident #002, which had now proven to be effective in preventing altercations with other residents. [s. 6. (10) (c)]

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 protect residents from abuse by anyone and shall ensure the residents were not neglected by the licensee or staff.

Inspector #613 reviewed a CI submitted to the Director. The CI indicated that resident #011 had been left in bed, in an inappropriate state, for a prolonged period of time on a specific date. The CI specified that on that date, at 1125 hours, Housekeeping Staff #131 informed PSW #123 that resident #011 was in an inappropriate state. PSW #123 responded that they had already provided care to the resident and they were busy. PSW #123 did not attempt to meet the needs of resident #011. Housekeeping Staff #131 proceeded to inform PSW#132 of the state of resident #011. PSW #132 went to resident's room and acknowledged the inappropriate state but did not provide care as resident was displaying behaviours. PSW #132 requested medication from RPN #134 to help settle resident #011 before attempting to provide care. At 1200 hours on that date, PSW #123 covered resident #011 with a sheet and a clothing protector, put them in the feeding position, and proceeded to feed the resident their lunch while still in the inappropriate state. At 1230 hours, Housekeeper #131 returned to resident #011's room where resident remained in the inappropriate state. After lunch, PSW #123

and #132 assisted other residents out of the dining room, instead of providing care to resident #011. Housekeeper #131 then approached PSW #133 at 1315 hours to inform them of the state of resident #011. At 1315 hours, PSW # 123 and #133 attended to resident #011's care needs. By this time, resident #011 had remained in bed, in the inappropriate state, for a total of one hour and 50 minutes.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #613 interviewed PSW #123, who confirmed they had neglected resident #011 by leaving them in an inappropriate state. The PSW stated they did not use their best judgement or provide care as per the home's expectations.

Inspector #613 reviewed the home's internal investigation of the incident which identified that PSW #123 received a letter of discipline and PSW #132 also received some discipline.

A review of the home's policy, "Zero Tolerance of Abuse and Neglect of Residents" last revised February, 2016, indicated that residents living in the home have the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individually and to be free from mental and physical abuse. The nature of employment in the Long Term Care Home environment demands an ongoing capacity for compassion and patience for residents that far exceeds the norm. There is a high standard of contact expected of those employed in the health care sector. All employees must protect the rights of each and every resident entrusted to their care. [s. 19. (1)]

2. Inspector #616 reviewed a CI submitted to the Director on a specific date, which related to resident to resident abuse. The CI report detailed how resident #013 inappropriately touched resident #014 without consent, while in a specific area of the home.

The Inspector reviewed the home's investigation record which included two internal "Safety Report Details", one for each resident involved. A contributing factor to this incident was documented in the report for resident #014 as "resident seated too close to co-resident".

The Inspector also reviewed the most recent Resident Assessment Instrument Minimum Data Set (RAI-MDS) quarterly assessment for resident #014. The assessment also identified that this resident required total dependence with locomotion on the unit.

Resident #013's care plan, identified that this resident required physical assistance, total dependence for locomotion on the unit. The care plan also identified certain inappropriate behaviours. An intervention for the protection of other residents was that this resident was to never be left alone with specific residents.

Progress notes with a focus on resident #013's responsive behaviours were reviewed by the Inspector for a three month period. Within this time period, the first documented incident of inappropriate behaviour was reported to the Director. Four days later, a progress note documented multidisciplinary rounds by the physician and summarized the specific inappropriate behaviours of resident #014. The physician's plan was to increase monitoring and separate resident #013 from certain residents.

During an interview with PSW #135, they stated to the Inspector that resident #013 was known to demonstrate socially inappropriate behaviours mainly toward certain residents. PSW #135 also stated an effective intervention to reduce or minimize the risk of certain behaviours was to not position resident #013, next to vulnerable residents. PSW #135 further stated that this resident required full assistance by staff while in their specific chair.

PSW #136 was interviewed by the Inspector on the same day. PSW #136 stated that staff were aware not to position certain residents near resident #013 as they were known to display inappropriate behaviours, and for this reason, redirected certain residents from getting too close to resident #013. If the certain residents could not be redirected, they moved resident #013.

In an interview with Clinical Manager #137, they clarified for the Inspector that their investigation notes, indicated that staff had inappropriately positioned co-resident #014 too close to resident #013. [s. 19. (1)]

3. Inspector #616 reviewed a CI submitted to the Director. The CI related to suspected resident to resident abuse that occurred that day. The CI indicated that PSW #135 observed resident #008 exit resident #009's room. PSW #135 then

entered resident #009's room and noted the resident's covering and attire had been disturbed in a way that resident #009 to complete. In the description of events leading up to the occurrence, it was documented that video recording from the security camera had been reviewed. On the recording, resident #008 paused until staff were not in the immediate area, at which time they entered resident #009's room and closed the door. According to the recording, resident #008 had been behind the closed door of resident #009's room for approximately four minutes before they were observed exiting the room.

Progress notes were reviewed by the Inspector from the date of resident #008's admission, to the date of the suspected abuse. The resident's physician had documented that the resident was not yet eligible to move from "acute" to "step down" home area, due to a previous critical incident with high risk behaviours. A progress note documented the resident's move to the "step down" home area. Two months after the move, the resident's physician had documented that resident #008 had left a letter for a recreation staff member with their requests about moving specific vulnerable residents closer to their room. The physician's documented plan was to continue to monitor for inappropriate behaviours.

The Inspector reviewed resident #008's care plan in effect at the time of the incident. There was no focus, goals, or interventions identified for this resident's known history of specific inappropriate behaviours.

Non-compliance has also been identified relating to O. Reg. 79/10, s. 53.(1) 2, where the licensee had not developed written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours of resident #008.

During an interview with Clinical Manager #137, they stated to the Inspector that resident #008's care plan should have included their known history of specific behaviours to protect vulnerable residents. [s. 19. (1)]

4. Inspector #616 reviewed a CI submitted to the Director, which related to resident to resident abuse. The incident was initially reported to the Long-Term Care Emergency Pager on the day of the incident. The CI report detailed how resident #002 pushed the chair where co-resident #023 was seated, which caused them to fall to the floor. Resident #023 sustained injuries.

The Inspector reviewed resident #002's progress notes related to responsive

behaviours with other residents for a three month period. Fifteen incidents of responsive behaviours by resident #002 toward other residents were documented prior to this CI.

The Inspector also reviewed resident #002's care plan in effect at the time of the incident. The care plan identified certain responsive behaviours. The interventions included: to try and keep resident away from other residents when in an agitated state and to increase monitoring, as the resident is highly responsive to other residents.

During interviews with RPN #113 and PSW#115 separately, they each stated that when resident #002 had close monitoring (a staff member with the task of monitoring residents' behaviours) in place, it was effective in preventing inappropriate behaviours by resident #002. During an interview with PSW #112, they verified to Inspector that they were the staff assigned to monitor the dining room on the evening of the date of the CI. They explained that they were given direction by the staffing coordinator to leave their assignment on resident #002's home area, to "cover" the short-staffing on another home area. PSW #112 stated that at the time the direction was received, they had expressed that resident #002 had begun to demonstrate certain behaviours, which were known indicators that the resident's behaviour was escalating. Despite this information, PSW #112 explained that they were instructed to attend the other home area that was short staffed.

During the Inspector's interview with the Clinical Manager #111, they stated that the "Monitor" assignment was in part, an intervention to the increased incidences of responsive behaviours by resident #002 to other residents, particularly in the dining room. They stated that on the date and time of the incident, the staff assigned to monitor the dining room, where the incident had occurred, had been reassigned to another home area due to short staffing. [s. 19. (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 ensuring that residents are protected from abuse by anyone and shall ensure the residents were not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to responsive behaviours were developed.

Inspector #616 reviewed a CI submitted to the Director, which related to suspected abuse by resident #008 to resident #009.

The Inspector reviewed resident #008's health care record which related to behaviour history. The record indicated that resident #008 was admitted to the home on a certain date, and a one page "24 hour Care Plan" of this date, listed certain inappropriate behaviours, with "close observation with certain residents

required". The "Admission Health Examination form" completed by a physician, documented that this resident had certain behaviours. It was identified here that inappropriate responsive behaviours were to be monitored. Prior to admission, an assessment had been completed using the RAI MDS. This assessment noted that resident #008 had demonstrated behavioural symptoms, and socially inappropriate or disruptive behavioural symptoms within the assessment period. In addition, a "Behavioural Assessment Tool", indicated that this resident had touched others inappropriately with a history of similar behaviours. Current interventions on this tool included regular monitoring and regularly redirecting (this resident) out of other residents' rooms.

The Inspector reviewed resident #008's care plan which did not include a focus for specific behaviours, nor were there interventions or strategies to prevent, minimize, or respond to the resident's inappropriate behaviours.

PSW #136 stated to the Inspector that resident #008 was known to have inappropriate behaviours. They stated that staff were aware to separate resident #008 from certain residents and that this information should be in the resident's care plan.

During an interview with PSW #135, they stated that they were aware of the resident's past history of certain responsive behaviours. They reported that they would have expected to see this behaviour with interventions included in the care plan, but after review with the Inspector, it was noted that it had not been included.

Clinical Manager #137 stated to the Inspector that information from the resident's health record related to inappropriate responsive behaviours should have been used in developing the resident's written plan of care and specifically the written care plan document for resident #008. [s. 53. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that written strategies including techniques and interventions, to prevent, minimize or respond to resident #008's responsive behaviours are developed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the missing or unaccounted controlled substance incidents in the home no later than one business day after the occurrence of the incident, followed by the report required

under subsection (4).

a) Inspector #603 reviewed a CI which occurred on a certain date, and submitted to the Director two days later. The CI alleged a controlled substance missing or unaccounted for.

The Inspector reviewed the home's investigation notes which revealed that on a certain date, at 1900 hours, during the narcotic shift count, RPN #120 noted a discrepancy with the number of a controlled substance left and questioned if doses were missing. From the initial review, it appeared that the doses were missing for two days. The home started their investigation on a certain date and the CI was reported to the Director on two days later.

An interview with the Clinical Manager #111 revealed that they had not reported the incident until two days after the discovery, because they wanted to confirm that the controlled substance was missing and not a suspicion.

b) Inspector #603 also reviewed a CI which occurred on a specific date and was submitted to the Director two days later. The CI alleged controlled substance missing or unaccounted for.

The Inspector reviewed the home's investigation notes which revealed that on a specific date, at approximately 0900 hours, RPN #120 noticed that the controlled substance tablets count for resident #033 was 20 and the day before, RPN #120 had added 40 tablets to this resident's stock. RPN #120 had also noted that the narcotic sheet did not have the same numbers as when they had added the 40 tablets, the day prior. RPN #120 reported this concern to leadership on call and an investigation was started on the next day. The CI was reported to the Director two days after the discovery.

The Inspector interviewed the Acting DOC who could not explain why the CI was only reported two days after the incident was discovered, and thought that the home was wanting to confirm that the controlled substance were missing and not a suspicion before they reported to the Director. [s. 107. (3)]

2. The licensee has failed to inform the Director of the names of any residents involved in the incident, within 10 days of becoming aware of the incident, or sooner if required by the Director.

Inspector #613 reviewed a CI reported to the Director, which identified that an unnamed resident (#032) sustained an injury on a specific date. The unnamed resident (#032) received treatment for their injury.

The Inspector met with Clinical Manager #111, who had submitted the CI to the Director. The Clinical Manager reviewed the CI and acknowledged that it did not contain the resident's name that was involved in the incident. [s. 107. (4) 2. i.]

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 Director is informed of missing or unaccounted controlled substance incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4); and ensuring that the Director is informed of the names of any residents involved in the incident, within 10 days of becoming aware of the incident, or sooner if required by the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff receive training in the duty under section 24 to make mandatory reports, before performing their responsibilities.

Inspector #616 reviewed three CI reports submitted to the Director, which related to resident to resident abuse by resident #002 to residents #019, #020, and #022.

The Inspector also reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect Training of Residents Education and Training", #LTC 5-52, approved June 2016. The policy indicated that during orientation and annually thereafter, each new employee reviewed the Zero Tolerance of Abuse and Neglect Policy. The policy also indicated that training and education included a review of "Policy and Procedures related to Reporting", and the "Licensee Reporting Decision Trees set by the MOHLTC (Ministry of Health and Long-Term Care)".

During an interview with Clinical Manager #111, they stated to Inspector #616 that since they had started in their position, they had not received training on mandatory reporting.

Inspector #603 interviewed Human Resource's Secretary who stated that Clinical Manager #111 started their position five months before the inspection. [s. 76. (2) 4.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) 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,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) 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. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident was notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Inspector #616 reviewed a CI submitted to the Director, which related to an allegation of abuse to resident #006 by PSW #100 and PSW #101 on a specific date. The allegation was first reported to the Long-Term Care Emergency Pager, the day prior, on the same date that the home had received the initial information pertaining to the allegation. The CI also indicated that the resident's relative(s), friend(s), designated contact(s) and/or substitute decision maker(s) had not been contacted about these allegations.

The Inspector reviewed resident #006's progress notes and found no documentation that any of the previously mentioned contacts had been notified of this occurrence.

The Inspector reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications About Incidents of Abuse or Neglect", LTC #5-51, date approved February, 2016. The policy indicated that the "Director/designate who received the report of alleged witnessed or unwitnessed abuse or neglect would immediately notify (the) Substitute Decision Maker (SDM) or person requested by the resident of the incident if the resident was harmed, and within 12 hours for all other situations of alleged or witnessed abuse or neglect".

During an interview with the ADOC, they stated to the Inspector that they had not reported this allegation to the resident's SDM contacts, as the allegations were determined by the home to be unfounded. During this interview, they verified that LTC policy #5-51 was the most current, and that this policy stipulated the home's responsibility to notify the SDM within twelve hours for all other situations of alleged abuse or neglect. They stated that they had not reported this allegation of verbal/emotional abuse to the resident's SDM and should have. [s. 97. (1) (b)]

Issued on this 25 day of November 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LINDSAY DYRDA (575) - (A1)

Inspection No. / No de l'inspection : 2016_391603_0022 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 021254-16, 024815-16, 024818-16, 025633-16, 026004-16, 026028-16, 026753-16, 027410-16, 027482-16, 027744-16, 027972-16, 028010-16, 028086-16, 028269-16, 028347-16, 028383-16, 028538-16, 029749-16, 030063-16 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Nov 25, 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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Myrna Holman

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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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall review and revise the plan of care for resident #021 based on the resident's current care needs, including but not limited to mobility, transferring, toileting, fall risk, aids to activities of daily living. Once the review and revision have been completed, ensure that the new plan of care is communicated to all staff caring for resident #021.

The licensee shall review and revise the plan of care for resident #002 based on the resident's needs, including but not limited to responsive behaviours. The home must continue with the existing "monitoring shifts" to protect other residents and prevent further altercations until the resident's behaviours no longer exist. Resident #002's behaviours will also be discussed at every shift change in order to assess continued or improved behaviours and this will continue until the resident's behaviours have become manageable.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #603 reviewed a Critical Incident (CI) Report submitted to the Director, which related to an injury/hospital transfer/significant change in status. According the CI report, resident #021 was found on the floor and the staff assumed it was a fall. Four days before the CI, resident #021 was found sitting on the floor next to their bed. Later that day, resident #021 was observed to be injured, and they were sent to the hospital for x-rays and later returned.

During the inspection, Inspector #603 observed resident #021 sitting in a specific chair.

The Inspector interviewed PSW #140 who was attending resident #021. PSW #140 explained that the resident used a specific chair to ambulate but they were able to get up on their own, transfer independently, but with some difficulty. PSW #140 further explained that staff had to assist and monitor resident #021 closely as they had recent falls, when attempting to ambulate on their own.

The Inspector also interviewed attending RN #139 who explained that the resident had been using a specific chair because they were unsteady on their feet, had tried to get up on their own, and had previously fallen. For these reasons, RN #139 further explained that the resident required closer monitoring.

The Inspector reviewed resident #021's current care plan which identified focuses for "Toileting, Transferring, Bed Mobility, Walk in Room, Walk in Corridor, Locomotion on Unit", and all of these focuses had "independent, no help or oversight needed, or no physical help needed" as part of the interventions. The care plan also had a focus on "Aids to Daily Living" and the intervention indicated that the resident was fully independent without devices. Under the focus of "Falls/Balance", there was no intervention for specific chair requirement or close monitoring.

LTCHA, 2007 S.O. 2007, s. 6. (10) (b) was issued previously as WN during Inspection #2016_333577_0011, a WN and CO during Inspection

#2015_435621_0012 (complied), and a WN and CO on Inspection #2015_333577_0012.

The decision to issue this compliance order was based on the scope which was isolated, the severity which indicated actual harm, and the compliance history which despite previous non-compliance (NC), NC continues with this area of the legislation. (603)

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

Inspector #616 reviewed a CI submitted to the Director, which related to resident to resident abuse on a specific date. The CI detailed how resident #002 pushed the chair where resident #023 was seated, which caused them to fall to the floor. Resident #023 sustained an injury.

The Inspector reviewed resident #002's progress notes related to responsive behaviours with co-residents for a period of three months. Fifteen incidents of resident #002's responsive behaviours were documented.

The Inspector reviewed a progress note from a third party, dated before the CI. It was noted that resident #002 continued to have responsive behaviours with co-residents, but that this resident was easily redirected, as long as there was always a staff member in close proximity to resident #002 when around other residents.

The Inspector reviewed resident #002's care plan effective at the time of the incident and behaviour problems were identified. One of the interventions to prevent or minimize behaviours was to keep co-residents away from resident #002 when displaying responsive behaviours, and to increase monitoring as resident #002 was highly responsive to other residents.

During the Inspector's interview with the Clinical Manager #111, they stated that prior to the physical altercation resulting in resident #023's injury, a four hour "monitor shift" had been implemented from Monday to Sunday from 1600-2000 hours. Further, an additional "monitoring shift" had been initiated Monday through Friday

from 0700-1500 hours, above the regularly scheduled PSW staffing complement. Clinical Manager #111 stated that the monitor assignment was in part, an intervention to the increased incidences of responsive behaviours by resident #002 to other residents. They stated as a result of this specific CI report, they had assigned one to one monitoring of resident #002 by a staff member who was responsible only for monitoring and intervening resident #002, which had now proven to be effective in preventing altercations with other residents.

LTCHA, 2007 S.O. 2007,s. 6. (10) (c) was issued previously as WN during Inspection #2016_333577_0011.

The decision to issue this compliance order was based on the scope which was isolated, the severity which indicated actual harm, and the compliance history which despite previous non-compliance (NC), NC continues with this area of the legislation. (616)

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

Dec 31, 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

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

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

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

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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 25 day of November 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDSAY DYRDA - (A1)

Service Area Office /
Bureau régional de services : Sudbury