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 sous la Loi de 2007 sur les foyers de soins de longue durée

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2017	2017_616542_0003	032807-16, 033219-16, 034705-16, 035190-16	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX3251 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

JENNIFER LAURICELLA (542), JULIE KUORIKOSKI (621), RYAN GOODMURPHY (638)

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 9-12, 2017.

This Critical Incident (CI) report was related to four intakes regarding the following;

Two logs, related to falls prevention.
Two logs, related to staff to resident abuse and neglect.

A Follow Up and Complaint Inspection were conducted concurrently. Please refer to Follow Up inspection # 2017_616542_0002 and Complaint inspection #2017_616542_0001 for details.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Nurse Manager (s), Behavioural Supports Ontario (BSO) staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreational Therapy, Vice President of Senior's Health, maintenance staff, housekeeping staff, Resident Assessment Instrument (RAI) Coordinator, residents and family members.

The inspectors conducted daily observations of the provision of care and services to the residents, a review of resident health care records, staff training records, specific home investigation files and relevant policies, procedures and programs were reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 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.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to not be neglected by the licensee or staff.

A Critical Incident System (CIS) was submitted to the Director, by Nurse Manager #105 for an incident of staff to resident neglect. The report identified that resident #008 was found over an extended period of time to not have received any care according to their care plan.

Inspector #621 reviewed the plan of care for resident #008 which identified that the resident required assistance from staff for continence care, restraint monitoring and repositioning at least every two hours.

During an interview with Nurse Manager #105 on January 11, 2017, they reported to the Inspector that they had reviewed the home's video footage and confirmed that the evidence clearly showed that resident #008 was not provided with care for the extended period of time.

During an interview with PSW #104 on January 11, 2017, they reported to Inspector #621 that, the day that resident #008 was not provided with care they were part of their assignment. PSW #104 also confirmed that they did not document that any care was provided.

On January 12, 2017, Inspector's #621 and #612 interviewed the Vice President (VP) of Seniors' Health and the Administrator. It was acknowledged by the VP of Senior's Health that they received an email from the Recreational Therapist #110 that was forwarded by the Administrator. The email was concerning an incident of alleged neglect of resident #008. The VP of Seniors' Health further identified that they investigated into the matter further and confirmed through video footage that resident #008 had been neglected. [s. 3. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right not to be neglected by the licensee or staff, to be implemented voluntarily.

WN #2: 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 a person who had reasonable grounds to suspect that improper or incompetent treatment of a resident that resulted in harm or risk of harm to the resident, immediately reported the suspicion and information upon which it was based to the Director.

A Critical Incident System (CIS) report was submitted to the Director, by Nurse Manager #105 for an incident of staff to resident neglect. The report identified that resident #008 was found over an extended period of time to not have received any care according to their care plan.

During an interview on January 10, 2017 with Nurse Manager #105, they reported to Inspector #621 that they received an email from the Recreational Therapist #110 who reported an incident of neglect. Nurse Manager #105 then indicated that they forwarded it to the Administrator. Nurse Manager #105 reported that they had been away during the time of the incident and the Administrator had been their designate. Nurse Manager #105 also reported that the Administrator confirmed to them that the email from Recreation Therapist #110 was received and then forwarded on to the VP of Seniors' Health for follow up.

On January 12, 2017, Inspector's #621 and #612 interviewed the VP of Seniors' Health and the Administrator who reported that the Recreational Therapist #110 sent an email to the Administrator, regarding a suspected incident of resident neglect and forwarded it to the VP of Seniors' Health for follow up. It was acknowledged by the VP of Seniors' Health that they received this email from the Administrator on a specific day however they, waited until the next day, to obtain more details about the incident from the Recreational Therapist who submitted the email about the alleged incident of neglect. The VP of Seniors' Health confirmed that the incident of neglect occurred, and then proceeded to contact Registered Nurse #111 on duty and directed them to notify the Director, a day after the incident occurred.

Inspector #621 completed a review of 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", last revised February 2016, which indicated that the Director/designate and/or VP of Seniors' Health must be notified immediately and that they would notify the Director by phone. [s. 24. (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 to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment of a resident that resulted in harm or risk of harm to the resident, immediately reported the suspicion and information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident of abuse or neglect, or at an earlier date if required by the Director. O.Reg.79/10, s.104(2).

A Critical Incident System (CIS) report was submitted to the Director, by Nurse Manager #105 for an incident of staff to resident neglect. The report identified that resident #008 was found over an extended period of time to not have received any care according to their care plan.

During an interview on January 10, 2017 with Nurse Manager #105, they reported to Inspector #621 that they had been away during the time of the incident and that the Administrator and VP of Seniors' Health had started an investigation into the incident during their absence. Nurse Manager #105 further reported that on their return to work 10 days after the incident occurred, they became aware of the incident, and that a Critical Incident (CI) report had not yet been initiated. They indicated that they then proceeded to initiate a CIS that was submitted to the Director the next day.

On January 12, 2017, Inspector's #621 and #612 interviewed the VP of Seniors' Health and the Administrator. It was confirmed that they had waited until the return of the Nurse Manager #105 before a report using the online Mandatory Critical Incident System was submitted, 11 days after the home became aware of the suspected incident of neglect . [s. 104. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident of abuse or neglect, or at an earlier date if required by the Director, to be implemented voluntarily.

Issued on this 10th day of February, 2017

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

Original report signed by the inspector.