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**

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


## 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 |
|---|---|---|---|
| Jan 6, 2020 | 2019_740621_0037 | 020387-19 | Complaint |

### 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

JULIE KUORIKOSKI (621), DAVID SCHAEFER (757), DEBBIE WARPULA (577), HILARY ROCK (765), KEARA CRONIN (759), LAUREN TENHUNEN (196), MELISSA HAMILTON (693)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): December 16 - 19, 2019.**

**The following intake was inspected during this Complaint Inspection:**
**- One intake, related to alleged resident-to-resident sexual abuse.**

**During the course of the inspection, the inspector(s) spoke with a Clinical Manager (CM), a Nurse Practitioner (NP), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.**

**The Inspector also conducted a daily tour of the resident care area; observed resident-to-resident interactions; and reviewed the home's supporting documentation, including relevant health care records, reporting and investigation records, as well as specific licensee policies, procedures and programs.**

**The following Inspection Protocols were used during this inspection:**
**Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 abuse of a resident by anyone, had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was received by the Director on a day in October 2019, alleging resident-to-resident abuse.

During an interview with the complainant, they reported to Inspector #621 that they had observed about two and one-half weeks prior to a particular date in October 2019, resident #017 touch another resident, who they believed was resident #035, on a particular location of their body. The complainant reported that they had submitted a written complaint to Clinical Manager #117, on a certain date in October 2019, regarding the incident.

Inspector #621 reviewed the Long-Term Care Homes reporting website and was unable to locate a Critical Incident System (CIS) report submitted by the home, for the abuse allegation made by the complainant on the aforementioned date, or anytime thereafter.

A review of Extendicare's policy titled "Critical Incident Reporting (ON) – RC-09-01-06", last updated June 2019, identified that mandatory reporting under the Ontario Long-Term Care Homes Act (LTCHA), s.24(1), requires a person to make an immediate report to the Director where there is a reasonable suspicion that certain incidents occurred, or may occur, including abuse of a resident by anyone that resulted in harm or a risk of harm to the resident.

During an interview with Clinical Manager #117, they confirmed to Inspector #621 that they had received a written complaint from the complainant on the identified date in October 2019, alleging witness of abuse of an unnamed resident by resident #017; and had submitted (as part of the home's complaint's reporting process), a copy of the complainant's correspondence to the Director on the same date, along with the home's follow up response to the complainant on another date in October 2019. However, Clinical Manager #117 acknowledged that they had not immediately reported the allegation of abuse by the complainant to the Director, on the specified date in October 2019, (or anytime thereafter), as part of the mandatory CIS reporting process. [s. 24. (1)]

---

**Issued on this 9th day of January, 2020**

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

**Original report signed by the inspector.**