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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 2, 2018	2018_657681_0002	020368-17, 022260-17, 023326-17, 024607-17, 026441-17, 026613-17, 027803-17, 028821-17	Complaint

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

STEPHANIE DONI (681), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), LISA MOORE (613), SHEILA CLARK (617), TIFFANY BOUCHER (543)

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): January 22 - 26, 2018.

The following intakes were inspected on during this Complaint inspection:

- Six intakes related to resident care concerns.

- One intake related to an inappropriate bed refusal.

- One intake related to medication administration.

A Critical Incident System (CIS) inspection #2018_657681_0001 was conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Clinical Managers, Resident-Assessment-Instrument (RAI) Coordinators, Manager of Building Services, Psychogeriatric Resource Consultant, Recreation Therapists, Physiotherapists (PTs), Physiotherapy Assistants (PTAs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Therapeutic Recreation Aids, Security Guards, family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Dignity, Choice and Privacy
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

2 WN(s)
1 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the Director, which indicated that resident #003 was to receive physiotherapy services, but they did not believe physiotherapy staff were providing any services to the resident.

Inspector #621 reviewed resident #003's plan of care, which identified that this resident was to receive specific therapeutic activities from a Physiotherapy Assistant (PTA) to improve and/or maintain functional mobility.

During an interview with PTA #132, they reported to Inspector #621 that they were unfamiliar with how to access the resident's "Therapy" care plan on the electronic medical record (EMR), and that written care plans were not accessible to the PTA's.

With the assistance of another PTA in the Physiotherapy department, PTA#132 reviewed the most current "Therapy" care plan for resident #003, last updated by PT #131. On review of the "Therapy" care plan, PTA #132 confirmed that they were not aware of the details of this resident's complete plan of care, and had not been providing the therapeutic activities consistent with this resident's plan of care.

During an interview with PT #131, they reported to Inspector #621 that they oversaw all activities within the Physiotherapy department at the home, including the provision of training and direction on use of the home's electronic medical record, for PTA's to access each resident's most current "Therapy" plan of care. On review of resident #003's documentation, the PT identified to the Inspector that they would be reviewing their internal processes to ensure PTA staff were aware of the most current plan of care for each resident, and that care was being provided to residents as per their plan of care.

During an interview with Interim Clinical Manager #103, they reported to Inspector #621 that it was the expectation that Physiotherapist #131, who directed therapy services at the home, ensured that PTA's under their direction were providing therapies consistent with each resident's plan of care.

2. A CIS report was submitted to the Director related to a fall which resulted in a resident being transferred to hospital. The CIS report indicated that resident #028 fell asleep while they were sitting in a common home area and, as RPN #153 was assisting the resident back to their room, the resident's slipper became caught in a mobility aid and caused resident #028 to fall. The resident was transferred to hospital following the fall.

During an interview with Inspector #681, RN #154 stated that the mobility aid that resident #028 was using when they fell was not their own.

Inspector #681 reviewed a Letter of Counsel addressed to RPN #153, which indicated that at the time of the fall, resident #028 was using a mobility aid that was not their own and that having resident #028 use a mobility aid for comfort was not included within their plan of care.

During an interview with Inspector #681, Clinical Manager #105 stated that through the home's investigation, it was determined that care was not provided as per resident #028's plan of care.

A Compliance Order (CO) was issued to the licensee on December 27, 2017, to address failure to comply with s. 6 (7) of the LTCHA, 2007 during Complaint Inspection #2017_509617_0018. The compliance due date of this CO was February 28, 2018.

3. The licensee has failed to ensure that the resident's plan of care was 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.

A complaint was submitted to the Director related to care concerns for resident #037.

Inspector #543 reviewed resident #037's most recent care plan, which identified under the restraint and falls/balance sections, a specified type of bed rails were to be used when the resident was in bed. The falls (RAP) section identified that a different type of bed rails would be engaged when the resident was in bed. The bladder section of the resident #037's care plan indicated a specific toileting intervention.

Inspector #543 interviewed PSW #109 who verified that resident #008 required a specific type of bed rails while in bed. PSW #109 indicated that the resident's care plan was inconsistent with the resident's current needs and needed to be updated.

The Inspector reviewed the home's policy titled "Plan of Care – LTC 2-20" last approved February 2016, which indicated that as the resident's status changes, members of the interdisciplinary team were to update the plan of care so that at any point in time, the care plan continued to be reflective of the current needs and preferences of the resident.

Inspector #543 interviewed RN #118 who stated that resident #008 no longer required a specific continence intervention. RN #118 also stated that this resident did not use a specific type of bed rails. The RN verified that the care plan should have been updated to reflect the resident's current needs.

4. A CIS report was submitted to the Director regarding an incident of resident to resident abuse that resulted in injury. The CIS report indicated that resident #007 was hit by resident #008 while they were participating in a program. The CIS report identified that resident #008 had begun to exhibit responsive behaviours and resident #007 grabbed resident #008's arm requesting them to stop. Resident #008 responded by slapping resident #007, resulting in injury.

Inspector #617 observed resident #008 be provided heightened monitoring by Therapeutic Recreation Aid #123 in an activity room on four separate occasions. On each of these occasions, the Inspector observed resident #008 periodically exhibit responsive behaviours.

The Inspector reviewed resident #008's progress notes for a specified period of time. Documentation revealed that, during this specified period of time, resident #008 exhibited responsive behaviours on 20 separate occasions. Resident #008's progress notes

indicated that on a particular date, an interdisciplinary meeting had taken place.

In an interview with Interim Clinical Manager #104, they confirmed that the outcome of the interdisciplinary meeting was that unit staff were to complete a Dementia Observation Screen (DOS) for two weeks to document resident #008's behaviour. Resident #008 was also to be re-referred to the Behavioural Support Outreach team.

A review of resident #008's health care record for a specific period of time revealed that the DOS observation documentation was missing. A review of resident #008's care plan indicated that their responsive behaviour strategies, did not include the resident's responsive behaviours that resulted from their assessed triggers. The record review determined that resident #008's responsive behaviour care plan strategies were not updated as planned from the interdisciplinary meeting.

In an interview with Interim Clinical Manager #104, they confirmed to the Inspector that the documented DOS for resident #008 and updated strategies to manage the resident's behaviours from BSO were not updated in the resident's plan of care.

5. Two CIS reports were submitted to the Director, which indicated that resident #003 had left the home on a casual leave of absence and was later located at an acute care facility and treated for a change in condition. The CIS reports identified that resident #003 was capable of leaving the home independently and had two specific medical diagnoses.

During a record review of resident #003's orders, Inspector #577 found a Registered Dietitian's (RD) order which indicated that a specific nutrition intervention was to be provided when the resident was leaving the unit.

A review of resident #003's current care plan did not include the RD's order under the nutritional interventions.

During an interview with PSW #108, they reported that staff were to remind the resident to sign themself out prior to leaving the unit, but were unaware that staff needed to offer the resident anything when they left the unit.

During an interview with the DOC, the Inspector reviewed the current care plan interventions and the RD order. The DOC acknowledged that resident #003's plan of care had not been revised to include the RD's order. [s. 6. (10) (b)]

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 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:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met when a resident was being restrained by a physical device under section 31 of the Act: 4. That the resident was released from the physical device and repositioned at least once every two hours.

A complaint was submitted to the Director related to care concerns for resident #037.

Inspector #543 reviewed resident #037's most recent care plan related to restraints. The care plan identified that the resident had a specific device in place and that the resident was to be checked every hour, and repositioned every two hours as per the home's restraint policy.

Inspector reviewed the home's "Least Restraint Use" (LTC 3-100) policy, which indicated that staff would release and reposition a restrained resident at least every two hours.

On a particular date, Inspector #543 observed this resident from 0941 hours until 1247 hours. The resident was seated in a common area of the unit with a specific device in a place. During this period of time, the resident was not repositioned and the device was not released.

Inspector #543 interviewed RN #118 who indicated that resident #037 could not remove the specific device and, therefore, the device was a restraint. RN #118 verified that staff were required to release and reposition the resident every two hours.

The Inspector interviewed the DOC who verified that the resident should have been repositioned every two hours and that their device should have been released as per the home's restraint policy. [s. 110. (2) 4.]

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 resident who is being restrained by a physical device under section 31 of the LTCHA, 2007, be released from the physical device and repositioned at least once every two hours, to be implemented voluntarily.

Issued on this 23rd day of February, 2018

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

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

Ministére 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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STEPHANIE DONI (681), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), LISA MOORE (613), SHEILA CLARK (617), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2018_657681_0002
Log No. / No de registre :	020368-17, 022260-17, 023326-17, 024607-17, 026441-17, 026613-17, 027803-17, 028821-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 2, 2018
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, P.O. Box 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Hogarth Riverview Manor 300 Lillie Street, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Judy Plummer

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.O. 2007, c.8, 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 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 the resident's care needs change or care set out in the plan is no longer necessary, specifically but not limited to:

A) Resident #037, regarding their falls prevention and continence care interventions.
B) Resident #008, regarding their responsive behaviour interventions.
C) Resident #003, regarding their nutritional interventions.
D) All other residents whose care needs have changed.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's plan of care was 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.

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to be used when the resident was in bed. The falls (RAP) section identified that a different type of bed rails would be engaged when the resident was in bed. The bladder section of the resident #037's care plan indicated a specific toileting intervention.

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During an interview with the DOC, the Inspector reviewed the current care plan interventions and the RD order. The DOC acknowledged that resident #003's plan of care had not been revised to include the RD's order.

During previous inspections (#2016_264609_0006, #2016_333577_0011, #2017_509617_0018, #2017_633577_0021, #2015_333577_0012, #2015_435621_0012, #2016_391603_0022), Written Notifications (WN) were issued to the home on March 7, 2016, and May 25, 2016, Voluntary Plans of Correction (VPC) were issued on December 18, 2017, and December 27, 2017, and Compliance Orders (CO) were issued to the home on October 29, 2015, February 16, 2016, and October 11, 2016.

The decision to issue a compliance order was based on the severity, which indicated actual harm/risk to the residents of the home, the scope, which was isolated, and the compliance history; which despite previous non-compliance identified in the aforementioned inspection reports, non-compliance continued in this part of the legislation. (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

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 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, 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
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 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

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 2nd day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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 Inspector / Nom de l'inspecteur : Stephanie Doni

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