Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 31, 2019	2019_671684_0037	017369-19, 018494-19, 018533-19, 018817-19	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

SHELLEY MURPHY (684), AMY GEAUVREAU (642), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), TRACY MUCHMAKER (690)

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): October 21-25, 2019.

The following intakes were inspected upon during this Complaint Inspection:

One Log related to resident care;

One Log related to a concern regarding a mobility aid, and;

Two Logs related to staffing.

Follow Up inspection #2019_671684_0035 and Critical Incident System inspection #2019_671684_0036 were conducted concurrently with this Critical Incident System inspection.

PLEASE NOTE: Non-compliance of a Written Notification (WN) related to r. 30(1)(2) of the O. Reg 79/10, and; non-compliance of a Voluntary Plan of Correction (VPC) related s. 6(7) of the LTCHA 2007 were identified in a concurrent inspection#2019_671684_0036 have been issued in this report.

During the course of the inspection, the inspector(s) spoke with the Regional Director, Administrator, Previous Director of Care (DOC), Clinical Managers (CM), Physio Therapist (PT), Psychogeriatric Resource Consultant (PRC), Social Worker (SW), Therapeutic Recreationist (TR), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Contractors, residents and families.

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

The following Inspection Protocols were used during this inspection:

Dining Observation
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Snack Observation
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where under a program, staff used any equipment, supplies, devices, assistive aids or positioning aids, that the equipment, supplies devices, assistive aids or positioning aids were appropriate for the resident based on their condition.

A complaint was submitted to the Director, related to concerns that there were safety issues related to resident #022's mobility aid and that it needed repairs. The complainant then identified, that while looking at the mobility aid concerns, they also realized that it affected how resident #022 was using their mobility aid, and how it affected other activity of daily living interventions. The complainant brought forth these concerns to the home.

Resident #022's Substitute Decision Maker (SDM) identified, that they had been informed on a specified date in 2019, that there was something wrong with the resident's mobility aid, and the SDM was upset and did not know how long the mobility aid had

been damaged.

Inspector #642 had reviewed the home's investigation notes and noted on a specified date in 2019, that the mobility aid was damaged and reported it to the home's staff. When the individual who noted the damage returned a number of days later, the mobility aid was in the same condition, that's when they decided to inform the SDM.

Inspector #642 reviewed resident #022's care plan in the electronic Med-e-Care file, and under a specific focus there were interventions which related to the proper use of the mobility aid to ensure resident #022's safety.

The Inspector then reviewed the home's investigation notes, and within these notes the Clinical Manager (CM) #105 had reviewed video footage and had identified resident #022, had been incorrectly using the mobility aid on a number of specified dates in 2019, as a result of the application of the aid by staff. Resident #022 should have been using the mobility aid as per the intervention in the resident's care plan.

Inspector #642 interviewed the Registered Dietician (RD) #135, who stated that if the care plan said the resident should be using the mobility aid a specific way for safety, then the staff should be following the care plan.

Inspector #642 reviewed information the SDM had provided to the home that showed how resident #022 had alternative interventions put in place to try to ensure their safety.

During an interview with Inspector #642, Registered Practical Nurse (RPN) #106 identified that the process in the home for a damaged mobility aid, was to write the concern in a work order book, and to fax the order to the contractor, who does all the repairs for the mobility aids. When the Inspector and RPN reviewed this work order book, there was no work order for the repair of resident #022's mobility aid for a specified month in 2019.

Inspector #642 interviewed the Physio Therapist (PT) #108 who identified the mobility aid was damaged, and they explained the damage to the inspector. The PT stated staff had been using alternate interventions to accommodate for the damaged mobility aid.

Inspector #642 interviewed CM #105 who had investigated this complaint and reviewed the home's video camera footage to try and find out when the mobility aid was damaged. It revealed that the mobility aid was not in good working order for a specified period in

2019. The CM stated that no staff member had reported the damaged mobility aid; therefore, the staff did not use resident #022's equipment, or assistive aids properly, which made the mobility aide inappropriate for resident #022 based on their condition. [s. 30. (1) 2.]

2. During observations on a specified date in 2019, Inspector #577 observed resident #023 to be sitting in their mobility aid, the mobility aid was noted to be damaged.

A review of a record from the previous Director of Care (DOC) #136, on a specified date, indicated that the home had a contractor to manage their mobility aids and other assistive devices for repairs. The document further identified that every nursing unit would have a binder where work orders would be entered and faxed with urgent needs, i.e. damaged equipment. The clerks would fax the requests daily to the contractor when repairs were needed. The contractor would affix loner tags on all loaner equipment.

A record review provided from the contractor indicated that they would provide daily or weekly visits in the home and would setup each area with a service repair binder to be located at each care station. Upon arriving at the home, the service technician would take the binder and visit each resident listed; after the equipment was checked, the service technician would log/date the repair in the service binder; additionally, they would provide loaner equipment to the resident during the assessment process.

Inspector #577 reviewed the service repair binder on the unit, which indicated that staff were to document a maintenance log request and fax daily as required. A review of the work requisitions for resident #023 indicated the mobility aid was damaged and on a number of different dates and the works orders were faxed to the service repair contractor.

Inspector #577 spoke with PSW #137, who confirmed that the resident's mobility aid was damaged. The Inspector inquired when the resident's mobility aid would be repaired and PSW #137 showed the Inspector faxed copies of work requisitions sent to the contractor.

During an interview with PSW #138, they reported that when a resident needed repairs on their mobility aid, staff were responsible for filling out a work requisition and faxing it to the contractor. They further reported that a number of months ago, a contractor was on the unit, and they told them that they had been waiting for repairs on resident #023's mobility aid for a specified period of time, and the contractor worker took a picture of the work order.

During an interview with PT #108, they reported that the mobility aid resident #023 had been using was on lone and that the contractor was responsible for any repairs.

During an interview with CM #121, they reported to Inspector #577 that staff were responsible to fill out a contractor work requisition for mobility aid repairs and fax it to the contractor; and that staff should have notified the Registered Nurse (RN) or CM when they noticed that equipment had not been repaired by the contractor. They confirmed that resident #023's mobility aid had not been repaired for a number of months.

During an interview with the Regional Director, they reported to Inspector #577 that staff were required to fill out work requisitions and fax them to the contractor. They further reported that the contractor was in the home daily checking the binder work orders for repairs and that the contract owner contacted them and reported that they had received the faxed work requisitions for resident #023's mobility aid, but could not explain why the work wasn't completed. They further shared a copy of a document, from the owner of the contracted services to the home, which indicated that "after taking some time to review our files, we found that we did indeed receive a request to repair the mobility aid occupied by resident #023 and did not follow through with doing the necessary repairs. We have since repaired the mobility aid and have started reviewing our internal system of process. We will be at the home tomorrow morning to inspect the binders at each station as well as to do a quick inspection of some of the mobility aids in question". [s. 30. (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 the following is complied with in respect to the organized programs, and where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that there was, at least quarterly, a documented reassessment of each resident's drug regime.

Inspector #577 conducted a record review of resident #001's physician's orders, and identified that resident #001 did not have a current quarterly reassessment of their drug regime. A review of the previous quarterly medication review was completed and signed by the physician on a specified date in 2019, for a specified authorization period in 2019. The current quarterly medication review with a three month authorization period for a specified period in 2019, had not been signed by the physician. A review of the Electronic Medication Administration Record (eMAR) for resident #001 confirmed that staff had been administering resident #001's prescribed medication during the three month authorization period for the specified time in 2019.

A review of the home's medication policy, "Three Month Medication Review Check - #2.14", revised September 2018, indicated that each resident's medication orders were to be reviewed by the attending physician at least every 90 days; medication reviews served as prescriptions for the resident's medication during the three month duration indicated on the review.

A review of the unsigned quarterly medication review with a specified authorization period in 2019, indicated that a specified number of residents were missing physician signatures authorizing the administration of the residents' medications for that period in 2019. In total, 22 percent of the residents did not have a current and valid prescriptions for administration of their medications that had been administered since the first month of the three month period in 2019, that were currently being administered.

During an interview with the Clinical Consultant #140, they reported that the three month medication reviews served as prescriptions for the residents.

During an interview with the CM #101, they reported that their process was to obtain a physician review and signature of the resident's quarterly medication review every quarter and that was considered active orders until the physician reviewed and signed the next review. They confirmed that a specified number of residents had expired authorization for the administration of their medications for the identified three month period in 2019. [s. 134. (c)]

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 there is, at least quarterly, a documented reassessment of each resident's drug regime., to be implemented voluntarily.

WN #3: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A Critical Incident System (CI) report was submitted to the Director, concerning resident #001 who had unexplained altered skin integrity. The report indicated that the home had concluded that the altered skin integrity could have been caused by a specified intervention.

A Complaint was submitted to the Director, concerning the altered skin integrity to resident #001 and the family was not immediately informed.

During an interview with PSW #115 and PSW #133 respectively, they each reported to Inspector #577 that on a specified date in 2019, they noticed altered skin integrity on

resident #001 and had reported it to RN #134.

A record review of the investigation notes indicated that on a specified date in 2019, staff had discovered altered skin integrity on resident #001 and they had reported it to RN #134; and RN #134 had not informed the family of the altered skin integrity.

A review of the home's policy, "Care planning - RC-05-01-01", revised April 2017, indicated that the Substitute Decision-Maker(SDM) was to be provided an opportunity to have participated in developing individual care.

During an interview with the CM #101, they reported to Inspector #577 that the altered skin integrity had been reported to the family, one day later, on a specified date in 2019.

During an interview with the Regional Director, they reported that with any change in a resident's condition, the family were to be notified right away. [s. 6. (5)]

2. The licensee has failed to ensure that the 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, related to concerns that there were safety issues to resident #022's mobility aid and that it needed repairs. The complainant then identified, that while looking at the mobility aid concerns, they realized that it had affected how resident #022 was using their mobility aid, and how it affected other activity of daily living interventions. They emailed these concerns to the home on a specified date in 2019.

Inspector #642 reviewed resident #022's care plan in the electronic Med-e-Care file, and under a specific focus there were interventions which related to the proper use of the mobility aid to ensure resident #022's safety.

The Inspector then reviewed the home's investigation notes, and within these notes CM #105 had reviewed video footage and had identified resident #022, had been incorrectly using the mobility aid on a number of specified dates in 2019. Resident #022 should have been using the mobility aid as per the intervention in the resident's care plan.

Inspector #642 interviewed RPN #120, RN #113, and CM #121, and they all stated staff were supposed to be following the residents' care plans.

Inspector #642 interviewed RD #135, who stated that if the care plan said the resident should be using the mobility aid a specific way for safety, then the staff should be following the care plan.

Inspector #642 interviewed the CM #105 who had investigated this complaint and they had found after watching the home's video camera footage, the PSW's had not been following the resident's care plan, as required. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident/SDM was notified when the residents personal aids or equipment were not in good working order or require repair.

A complaint was submitted to the Director, related to concerns that there were safety issues with resident #022's mobility aid and that it needed repairs.

Resident #022's Power of Attorney (POA)/or SDM identified, that they had been informed by another individual that there was something wrong with resident #002's mobility aid. The SDM was upset that no staff member had informed them of this concern and they did not know how long the mobility aid had been damaged.

Inspector #642 had reviewed the home's investigation notes and noted that the individual had identified on a specified date in 2019, that resident #022's mobility aid was broken and reported it to the home's staff. Then when the individual returned a number of days later, the mobility aid was in the same condition, so that's when the individual decided to inform the SDM.

Inspector #642 interviewed CM #105 who had investigated this complaint and went back and reviewed the home's video camera footage to try and find out when the mobility aid was damaged. The CM identified the mobility aid was not in good working order for a number of days. The CM stated no staff member had reported the broken mobility aid, therefore the SDM had not been informed of resident #022's mobility aid as not being in good working order or needing to be repaired. [s. 38. (a)]

Issued on this 14th day of November, 2019

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

Original report signed by the inspector.