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

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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
Jan 6, 2020	2019_740621_0038	019749-19, 019750-19, 019751-19, 021900-19	Follow up

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 Follow up inspection.

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

The following Compliance Orders (CO), issued during inspection #2019_671684_0035 and #2019_768693_0021, were inspected during this Follow Up Inspection:
- One intake, regarding CO #001, related to r.53(4) of Ontario Regulation (O.Reg) 79/10;
- One intake, regarding CO #003, related to r.36 of O.Reg 79/10;
- One intake, regarding CO #002, related to r.30(1) of O.Reg 79/10; and
- One intake, regarding CO #001, related to s.6(7) of Ontario's Long-Term Care Act (LTCA), 2007.

During the course of the inspection, the inspector(s) spoke with the Long Term Care (LTC) Consultant from Extendicare Assist, Clinical Managers (CMs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Housekeeping Aide, and a Resident Home Worker (RHW).

The Inspector(s) also conducted a daily tour of the resident care areas; observed staff-to-resident care activities, resident-to-resident interactions; and reviewed the home's supporting documentation, including relevant health care records, staff training and auditing records, as well as specific licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Responsive Behaviours

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 30. (1)	CO #002	2019_768693_0021	621
O.Reg 79/10 s. 36.	CO #003	2019_768693_0021	757
O.Reg 79/10 s. 53. (4)	CO #001	2019_671684_0035	693
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_768693_0021	621

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During the follow up inspection, Inspector #621 completed a review of resident #005's most current care plan, with a particular focus, which was last updated on a certain date in November 2019. As part of this review, Inspector #621 identified a particular care intervention that was unclear.

During an interview with PSW #135, they identified that resident #005 was a safety risk due to a certain medical condition, and had interventions in place to mitigate this safety risk, on their Kardex and care plan. PSW #135 reviewed resident #005's most current Kardex with the Inspector and identified that the last update made was on a particular date in November 2019. On further review of the specified section of the Kardex, PSW #135 verified that there was a particular entry under "Interventions" which was unclear, and PSW staff would not know what they were specifically required to do.

During an interview with RPN #137, they identified to Inspector #621 that resident care plans were to be reviewed daily by PSWs, with any changes needed to the care plan to be communicated to the RPN or RN on duty. On review of resident #005's most current

Kardex and corresponding care plan, last updated in November 2019, they confirmed to the Inspector, that the specified intervention, provided unclear direction to staff and others providing care to resident #005.

During an interview with Clinical Manager (CM) #139, they reported that it was their expectation that PSWs were aware every day of the contents of resident's care plans; that if something was not clear, that they notified the RPN on duty, so that changes could be made. CM #139 confirmed that a particular section of resident #005's care plan provided unclear direction as a result of a documentation error, and that this error had not been identified by staff, including PSW staff responsible for completing audits of this resident's care plan, up until the time of the inspection. [s. 6. (1) (c)]

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, the resident's care needs changed or care set out in the place was no longer necessary.

During a follow up inspection, Inspector #621 completed a review of resident #001's care plan, with a specific focus, which was last updated on a particular day in November 2019. As part of this review, the Inspector identified a care intervention which required staff to apply a specific size and type of care product over a specified time period.

During observation of resident #001's room, Inspector #621 located a supply of a specific size and type of care product that was different than what was described in the resident's care plan.

During an interview with PSW #102, they reported to the Inspector that they provided care to resident #001, and that the resident required the daily application of one particular size and type care product during one time interval, and a different type of care product at a another time interval. On review of resident #001's most current care plan with a specified focus, PSW #102 confirmed that the care plan did not reflect resident #001's most current care needs with respect to the application of a particular size and type of care product, as it only identified one of the two product types that were required. When the Inspector inquired if there were any other locations on the unit where information concerning resident #001's product needs would be found, PSW #102 reported that this resident's information was also posted for staff reference, in a particular area of the home. They also identified that Resident Home Worker #144 was responsible for stocking the required care products throughout the home area. When PSW #102 checked with the Inspector on the location where resident #001's product information

was said to be alternatively kept, they were unable to locate a copy of product information, as PSW #102 described.

During an interview with Resident Home Worker (RHW) #144, they reported that they stocked required care products on the resident home area, and were well aware of each resident's product requirements. RHW #144 reported that resident #001 required one specific type and size of care product during one part of the day, and another product type during another part of the day. They also informed the Inspector that not all product information, found in certain areas of the home, was accurate. They further identified that although the home area did at one time have a consolidated list of resident's product information to refer to, it disappeared, and they now just went by memory when restocking product. When the Inspector inquired if there were any other residents who had recent changes to their product requirements, RHW #144 identified resident #027 recently changed from one size of a specific care product, to another, over a specific time interval each day.

On review of resident #027's most current care plan, with a specific focus, last revised on a particular day in December 2019, it identified that this resident required the use of a certain size and type of care product, over a specified interval of time.

During an interview with PSW #131, they reported that, resident #027 used to require one particular size of a certain care product, but now required a different size of the same care product, over the same time interval.

During an observation of a certain area of the home, PSW #132 along with the Inspector, identified the presence of product information, but that the information continued to identify that the resident required a certain size of product, which PSW #131 and #132 confirmed was no longer required. PSW #132 further reported to the Inspector that the unit once employed a secretary, and it was the secretary who used to update the product information found in specific locations of the resident home area. However, PSW #132 identified that the unit lost this position about a year prior, and that this specific responsibility was not reassigned to anyone, including the RHW since that time.

On review of resident #027's most current care plan, which a specific focus, PSW #131 confirmed that the care plan did not reflect resident #027's most current care needs with respect to their specified products requirements, as it continued to identify the use a certain size of care product, which was no longer accurate. When the Inspector inquired who was responsible for reviewing and updating resident care plans, PSWs #131 and

#115 identified that PSWs were responsible for checking resident Kardexes daily before starting their shift, and if there were identified issues, to inform the RPN on duty, who was responsible for reviewing and updating the resident's care plan.

During an interview with Clinical Manager (CM) #117, they reported to Inspector #621 that it was their expectation that PSWs were reviewing resident Kardex information daily before providing care, which included the size and type of care products required, if that specific information was not found anywhere else on the unit. CM #117 identified that if changes were required to the information located on a resident's Kardex and care plan, that PSW staff were to inform the RPN, who would then make the requisite changes. [s. 6. (10) (b)]

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 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 place is no longer necessary, to be implemented voluntarily.

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.