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
Feb 7, 2020	2020_655679_0004	023834-19, 000046-20, 000107-20, 001092-20, 001190-20	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

MICHELLE BERARDI (679), AMANDA BELANGER (736), AMY PAGE (749), JENNIFER NICHOLLS (691), 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 27-31, 2020.

The following intakes were inspected upon during this Complaint Inspection:

- Three complaint intakes related to resident care concerns, including abuse and neglect, skin and wound, the complaint processes, and falls.

Two Critical Incident System intake(s) related to the same concerns were completed during this Complaint inspection.

A Critical Incident System Inspection (2020_655679_0003) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Clinical Managers, Registered Dietitian (RDs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapy Assistants (PTAs), Resident Home Workers (RHWs), Food Service Workers (FSWs), 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, staff education records, complaint records, as well as relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, that the strategy was complied with.

In accordance with Ontario Regulation 79/10 s. 49. (1), the licensee was required to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of residents. Specifically, staff did not comply with the licensee's Falls Management policy (LTC 3-60), which was part of the licensee's Falls Prevention program.

A complaint was submitted to the Director related to the fall of resident #013. The complainant indicated that the resident had sustained a fall within the home and was transferred to the hospital for further assessment.

Inspector #736 reviewed resident #013's electronic health care record, which indicated that the resident had fallen on a specified date.

The Extendicare Falls Prevention and Management Program (LTC 3-60), last reviewed February 2017, and adopted by Hogarth Riverview Manor December 18, 2017, indicated that all residents were to be screened on admission, annually, with a change in condition that could potentially increase the resident's risk of falls/fall injury, or after a serious fall injury or multiple falls (if not already at high risk), by using a specified assessment.

Inspector #736 further reviewed resident #013's electronic health records and located that the specified assessment was completed on a specified date.

In an interview with Clinical Manager (CM) #113, they indicated to Inspector #736, that residents were assessed for their fall risk score using the specified assessment and that the assessment would be found in the resident's electronic records. Together, the CM and Inspector #736 reviewed resident #013's records, and the CM noted that the last specified assessment had been completed on a specified date. CM #113 indicated to the Inspector, that based on the home's falls policy, the specified assessment was to be completed annually, and had not been for resident #013; therefore, the falls policy of the home was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with Ontario Regulation 79/10 s. 50. (1) 1, the licensee was required to ensure that the skin and wound program provided for the provision of routine skin care to maintain skin integrity and prevent wounds, including the monitoring of residents. Specifically, staff did not comply with the licensee's policy titled Skin and Wound Program: Wound Care Management (RC-23-01-02), which was part of the licensee's skin and wound program.

A complaint and CI report were submitted to the Director related to the incompetent care of resident #013. The complaint and CI report indicated that resident #013 had an area of altered skin integrity.

Inspector #736 reviewed the home's internal investigation file related to the complaint of the altered skin integrity to resident #013. In the investigation, PSW #142 had indicated to the home that they had noted the area of altered skin integrity on resident #013; however, had not informed the registered staff on the home area immediately.

A review of the licensee's policy, titled Skin and Wound Program: Wound Care Management policy (RC-23-01-02), last reviewed August 2019, indicated that all staff were to promptly report changes in skin integrity observed during daily care and weekly bath/shower to the Nurse immediately for assessment.

In an interview with PSW #142, they indicated to Inspector #736, that they had noted an area of impaired skin integrity on resident #013; however, they did not immediately report it to the nurse as they had thought that it was already reported. The PSW indicated that by not reporting the area of impaired skin integrity to the nurse on the unit immediately, they had not complied with the home's skin and wound policy.

In an interview with CM #113, they reviewed the licensee's skin and wound policy with Inspector #736, which indicated that staff were to immediately report any skin

impairments to the registered staff. The CM indicated that PSW #142 had noted an area of impaired skin integrity on resident #013; however, based on the home's internal investigation, they had not told the registered nurse; and therefore, the PSW had not complied with the home's policy for skin and wound. [s. 8. (1) (a),s. 8. (1) (b)]

3. In accordance with Ontario Regulation 79/10 s. 50. (1) 1, the licensee was required to ensure that the skin and wound program provided for the provision of routine skin care to maintain skin integrity and prevent wounds, including the monitoring of residents. Specifically, staff did not comply with the licensee's policy titled Skin and Wound Program: Wound Care Management (RC-23-01-02), which was part of the licensee's skin and wound program.

A complaint was submitted to the Director regarding care concerns of resident #007. The complaint indicated that resident #007 had an area of altered skin integrity for a specified amount of time.

Inspector #679 reviewed the resident #007's medical file for a five month period and identified missing documentation regarding the specified area of altered skin integrity on a number of occasions.

Inspector #679 reviewed the policy titled "Skin and Wound Program: Wound Care Management" (RC-23-01-02) dated August 2019. The policy directed staff to initiate one assessment tool for each open area/wound. The policy further identified that staff were to complete the assessment tool if the condition was worsening or not improving as expected, but minimum every seven days.

In an interview with RPN #120, they identified that the home used a specified assessment to document on areas of altered skin integrity. RPN #120 further identified that registered staff were to document the specified characteristics of the altered skin integrity within the wound assessment.

In an interview with CM #135 they identified that a specified assessment was implemented in the home in 2019. Together, Inspector #679 and CM #135 reviewed three dates in which the Inspector identified there was no documentation indicating a specific characteristic of the altered skin integrity, within the assessment. CM #135 indicated that the specified characteristic for the altered skin integrity was not documented on the three dates, and confirmed that it was the expectation that the specified characteristic of the altered skin integrity was documented within each

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 where the Act or the Regulation required the licensee of a long-term care home to have institute, or otherwise put in place any strategy, that the strategy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for the resident included disease diagnoses.

During an observation of resident #013, Inspector #736 identified a specified intervention in place.

Inspector #736 reviewed resident #013's diagnoses in the electronic health record, as well as the resident's care plan and was unable to locate any indication as to why the specified intervention was in place.

In an interview with PSW #104, they indicated to Inspector #736, that resident #013 had a specified diagnosis and therefore required a specified intervention The PSW further indicated that diagnosis should have been identified in the resident's plan of care.

In an interview with RPN #105, they indicated to Inspector #736, that resident #013 required a specified intervention; and, indicated that they thought that the resident had a specified diagnosis. The RPN also indicated to the Inspector that the diagnoses were to be included in the resident's plan of care, as the staff would have needed to know what

specified interventions to take with the resident. Together, RPN#105 and the Inspector reviewed the resident's care plan, as well as diagnoses, and were unable to locate any indication that the resident had a specified diagnosis. The RPN indicated to the Inspector that the diagnosis should have been listed in the resident's plan of care.

In an interview with CM #113, they indicated that resident #013 had a specified diagnosis, and when a resident had this diagnoses it should be included in the resident's plan of care. Together, the CM and Inspector reviewed resident#013's plan of care, which did not include the specified diagnosis. CM #113 indicated to the Inspector that resident #013's plan of care was not based on the resident's diagnoses. [s. 26. (3) 9.]

2.During an observation of resident #003, Inspector #736 identified a specified intervention in place.

Inspector #736 reviewed resident #003's diagnoses in the electronic health record, as well as the resident's care plan and was unable to locate any indication as to why the resident required the specified intervention.

In an interview with RN #140, they indicated to Inspector #736, that resident #003 had a specified diagnosis and required a specified intervention. RN #140 further indicated that diagnosis should have been identified in the resident's plan of care. Together, RN #140 and the Inspector reviewed the resident's care plan, as well as diagnoses, and were unable to locate any indication that the resident had the specified diagnosis. RN #140 indicated to the Inspector that the diagnosis should have been listed in the resident's plan of care.

In an interview with CM #125, they indicated that resident #003 had a specific diagnosis; however, they were unsure if that was something that would be indicated on the resident's plan of care or diagnoses. Together, the CM and Inspector reviewed resident #003's plan of care, which did not include the diagnosis. CM #125 later indicated to the Inspector that they had confirmed that when a resident had a specific diagnosis, it should have been added to the resident's diagnoses list on the computer. CM #125 indicated to the Inspector that resident #003's plan of care was not based on the resident's diagnoses, as the specified diagnosis was not listed. [s. 26. (3) 9.]

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 the plan of care for each resident includes their disease diagnoses, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that when a resident had fallen, they were assessed using a clinically appropriate post-fall assessment.

A complaint and CI report were submitted to the Director related to resident #013, who had sustained a fall on a specified date.

Inspector #736 reviewed resident #013's electronic progress notes and noted that RPN #112 and RN #111, both documented that on a specified date, the resident had sustained an unwitnessed fall.

The Inspector reviewed the resident's electronic chart and was unable to locate a post fall assessment for the fall of resident #013 on the specified date.

In an interview with RPN #112, they indicated to the Inspector that they were present on the home area when resident #013 had sustained a fall. The RPN further indicated that after a resident had sustained a fall, the registered staff were to complete a post fall assessment in the electronic charting system. Together, RPN#112 and the Inspector reviewed resident #013's electronic chart and RPN #112 was unable to locate the corresponding post fall assessment for the fall that was sustained on the specified date. The RPN indicated to the Inspector that the post-fall assessment should have been completed.

A review of the licensee's policy, titled "Falls Prevention and Management" (RC-15-01-01), last updated February 2017, indicated that when a resident had sustained a fall, staff were to hold a post-fall huddle, ideally within the hour and complete a post fall assessment as soon as possible.

In an interview with CM #113, they indicated to Inspector #736 that when a resident had sustained a fall, the registered staff were to complete a post fall assessment in the resident's electronic health record. CM #113 further indicated that they had recalled resident #013 having sustained a fall on the specified date. Together, the CM and Inspector reviewed resident #013's electronic assessments and were unable to locate a post fall assessment completed after the fall on the specified date. The CM indicated to the Inspector that the post fall assessment should have been completed. [s. 49. (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 that when a resident falls, they are assessed using a clinically appropriate post-fall assessment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds, had been assessed by a registered dietitian who was a member of the staff of the home.

A complaint and CI report were submitted to the Director related to an allegation of improper care of resident #013. The complaint and CI report indicated that the resident had been found in a specified state, which resulted in areas of impaired skin integrity.

Inspector #736 reviewed resident #013's electronic progress notes, which indicated that

the resident had impaired skin integrity during a specified period. The Inspector was unable to locate any progress notes to indicate that the resident had been assessed by a Registered Dietitian (RD) as a result of the areas of impaired skin integrity.

In separate interviews with RD #114 and RD #141, they indicated to Inspector #736 that if a resident had an area of impaired skin integrity, registered staff would send a referral for an assessment. RD #141 further indicated to the Inspector that once a referral was received for a resident, they would document their assessment and interventions in a progress note within the resident's chart. RD #141 indicated they did not recall receiving any referral related to resident #013's impaired skin integrity for the specified month, and reviewed the progress notes for the resident to confirm that they had not assessed the resident. The RD indicated to the Inspector that if the resident had areas of impaired skin integrity, the staff should have sent a referral to ensure that the RD was able to assess the resident.

Inspector #679 reviewed the policy titled "Skin and Wound Care Program: Wound Care Management" (RC-23-01-02) which was dated August 2019. The policy indicated that staff were to complete a referral to the RD, where available, for all residents exhibiting altered skin integrity. The policy further indicated that the Dietitian was to complete an assessment, document and communicate to the interdisciplinary team any nutritional interventions to be implemented, and update the resident's plan of care as necessary.

In an interview with CM #113, they indicated to the Inspector that they were unsure of when the RD would have been involved with residents who had impaired skin integrity. The CM indicated that they were unsure if resident #013 had been assessed by the RD after having impaired skin integrity. The CM further indicated that due to being unsure of the home's policy, they were unsure if the RD should have been notified of the impaired skin integrity for resident #013. [s. 50. (2) (b) (iii)]

2. A complaint was submitted to the Director regarding care concerns of resident #007. The complaint indicated that resident #007 had an area of altered skin integrity for a specified period.

Inspector #679 reviewed resident #007's electronic progress notes, which indicated that on a specified date, staff identified an area of altered skin integrity. The Inspector identified that the RD assessment was completed on a specified date, a number of months after the discovery of resident #007's altered skin integrity.

In an interview with RPN #120, they identified that the RD would assess residents with altered skin integrity, and that a referral would be sent to the RD through email.

In an interview with RD #114, they identified that they were made aware when a resident developed an area of altered skin integrity through a referral or assessment. RD #114 identified that when they received referrals, they were addressed, but that they didn't always receive referrals. When asked what the typical time frame for assessing a resident with an area of altered skin integrity would be, RD #114 indicated that this would depend on the case load and priority, but that they would like to see the assessment completed within a month, or sooner if possible. RD #114 reviewed resident #007's electronic progress notes and identified that they there was an RD assessment completed in a specified month.

In an interview with CM #135, they identified that a referral should be sent to the RD for assessments. When asked what the typical time frame for assessing residents with an area of altered skin integrity was, CM #135 indicated that it was "usually a couple of days". Together, CM #135 and the Inspector reviewed the e-notes, and CM #135 identified the RD assessment was completed in a specified month. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that a resident exhibiting altered skin integrity, had been reassessed at least weekly by a member of the registered nursing staff.

A complaint and CI report were submitted to the Director related to an allegation of improper care of resident #013. The complaint and CI report indicated that the resident had been found in a specified state, which resulted in areas of impaired skin integrity.

The Inspector further reviewed progress notes and the home's internal wound assessments. The Inspector was unable to locate any documentation that resident #013's area of altered skin integrity had been reassessed by registered nursing staff for a specified period.

In an interview with RPN #105, they indicated to the Inspector that when a resident had an area of impaired skin integrity, they would be assessed with each dressing change, or treatment application in a progress note within the resident's chart, and also, weekly using a specified assessment. RPN #105 indicated that resident #013 had impaired skin integrity, and that it should have been assessed each time the treatment was completed, and weekly. Together, the RPN and Inspector reviewed the residents progress notes and assessments; the RPN was unable to locate any assessments of the resident's

impaired skin integrity for the specified period.

A review of the licensee's policy titled Skin and Wound Program Wound Care Management policy (RC-23-01-02), last reviewed August 2019, directed nursing staff to monitor resident skin condition with each dressing change, and re-assess at minimum every seven days in the assessments.

In an interview with CM #113, they indicated to Inspector #736 that registered staff were to reassess residents with impaired skin integrity at minimum, weekly, and that the reassessment was to be located in assessment. Together, the CM and Inspector reviewed resident #013's clinical chart and were unable to locate any weekly wound reassessment for the resident's area of altered skin integrity for a specified period. The CM indicated to the Inspector that they were aware that the resident had not had a reassessment of their impaired skin integrity during that time period; and, indicated that the resident should have had a weekly reassessment. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed: (iii) by a registered dietitian who is a member of the staff of the home and (iv) is assessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

Issued on this 10th day of February, 2020

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

Original report signed by the inspector.