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, 2021	2020_768693_0027	018167-20, 018596-20, 019142-20, 019773-20, 020239-20, 020326-20, 020537-20, 020771-20, 020865-20, 021069-20, 021313-20, 021401-20, 021616-20, 022143-20, 022254-20, 022369-20	Critical Incident System

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

MELISSA HAMILTON (693), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System

inspection.

This inspection was conducted on the following date(s): December 7 to 11, 2020, and December 14 to 17, 2020.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
-one intake, regarding incompetent care;

-six intakes, regarding alleged resident to resident abuse;

-one intake, regarding alleged family to resident abuse;

-two intakes, regarding resident falls;

-one intake, regarding missing controlled substances;

-four intakes, regarding alleged staff to resident abuse and neglect; and

-one intake, regarding a choking incident.

Complaint (CO) inspection #2020_768693_0026, and Follow Up inspection #2020_768693_0028 were conducted concurrently with this CIS inspection.

A compliance order related to regulation 36. of the O. Reg. 79/10 was identified in this inspection and has been issued in the Follow Up Inspection Report #2020_768693_0028, which was conducted concurrently with this inspection.

Findings of non-compliance related to sections 3. (1) 2, and 6. (7) of the Long-Term Care Homes Act, 2007, have been issued in the Follow Up Inspection Report #2020_768693_0028, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Extendicare Assist LTC Consultant, Clinical Managers (CMs), Manager of Food Services, Psychogeriatric Resource Consultant, Registered Nurses (RNs), Registered Dietitian (RD), Learning and Telemedicine Facilitator, Resident Assessment Instrument Coordinators (RAI Coordinators), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident

Home Workers (RHWs),residents, and their family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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 system, the system was complied with.

In accordance with O. Reg. 79/10, s. 114. (1), the licensee was required to ensure that the medication management system provided safe medication management and optimized effective drug therapy outcomes for a resident.

Specifically, staff did not comply with the licensee’s Narcotic Security policy, Controlled Substance Disposal policy and Narcotic and Controlled Drug Control policy.

The licensee’s policies identified that narcotics and controlled substances were to be accounted for and documented at the time of administration and controlled substances were subject to special handling, storage, disposal and record keeping requirements and with federal and provincial laws and regulations.

A review of the home’s investigation file identified that a resident was ordered a medication, and an RPN noted that a resident's medication card containing an identified number of tablets was missing/unaccounted.

The investigation concluded the following;

-An RPN disposed a resident's medication card into the garbage in the unit’s medication room. The RPN had worked a 16-hour shift on this date and had pre-poured a resident's scheduled medication.

-Three RPNs acknowledged that they had not completed an efficient/accurate narcotic count with the outgoing RPN, as the count should have identified that a resident's medication card was missing/unaccounted.

-A resident had missed their scheduled medication dosage.

-All RPNs received disciplinary action for not following the licensee's narcotic and controlled drug control policies.

During an interview with the DOC, they confirmed that all RPNs involved with this occurrence had not followed the licensee's Narcotic and Controlled Drug Control policies.

There was increased risk that registered practical nurses were not following the licensee's medication management system and not providing safe medication management for narcotics and controlled substances and were not optimizing effective drug therapy outcomes for a resident.

Sources: Critical System Incident report, interviews with DOC and other staff, the home's investigation file and review of a resident's electronic chart. [s. 8. (1) (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 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, is complied with., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1.The licensee has failed to ensure that an RPN used a treatment intervention on a resident's lower legs in accordance with manufacturers' instructions.

A review of a progress note, indicated that a resident had complained of pain to their lower legs, and an RPN found that the resident's treatment interventions to both lower legs were applied incorrectly, and caused injuries to the resident.

During an interview with a CM, they advised that an RPN had used the treatment interventions incorrectly. They further advised that as a result, a resident suffered bruising to both lower legs and a skin tear to their right lower shin.

Sources: Critical Incident System report, progress notes, manufacturer's instructions, the LTCH's investigation file, employee file and training records, and interviews with an RPN and other staff. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1.The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A CIS report was submitted to the Director, regarding the improper care of a resident, related to continence care concerns. Inspector #693 reviewed the home's investigation file, and the resident's plan of care and identified that the resident required total assistance with all personal care, including continence care, and staff were to provide the resident with continence care as early as possible on the day shift; prior to breakfast. In addition, the Inspector identified that on an identified date, the resident was not provided with continence care on the day shift until 1230 hrs; after the resident's family member had reported the missed care at 1130 hours that day.

During an interview with a CM, they indicated that the resident's care plan relating to continence was not implemented.

Sources: CIS report; LTCH's investigation file; interviews with a CM and other staff; training records; a resident's care plan; progress notes; and "Continence Management Program, LRC-14-01-01" (dated December, 2020). [s. 51. (2) (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 each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #4: 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. (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 failed to ensure that a resident's falls care plan 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.

During an observation of the resident's room, the Inspector identified a falls prevention intervention, but the intervention was not included in the resident's plan of care.

During interviews with an RPN and a PSW, they reported that the resident was a high falls risk and required interventions. On review of the resident's Kardex, the RPN and PSW confirmed that the resident's Kardex, which was part of the resident's plan of care, was not updated to include all falls intervention strategies.

Sources: Post Falls Assessment; resident's care plan and kardex; and interviews with a PSW, an RPN and others. [s. 6. (10) (b)]

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

Issued on this 14th day of January, 2021

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

Original report signed by the inspector.