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

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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
Jun 10, 2021	2021_624196_0007	003500-21, 004085-21, 005458-21, 005566-21, 007549-21	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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577)

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): May 17 - 21 and May 25 - 28, 2021.

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:
-one intake regarding a resident fall with injury;
-one intake regarding an improper transfer;
-two intakes regarding resident to resident altercations; and
-one intake regarding improper resident care.

Follow Up inspection #2021_624196_0008 and Complaint inspection #2021_624196_0006 were conducted concurrently with this Critical Incident System (CIS) inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (Acting DOC), Clinical Managers (CMs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Staffing Coordinator, Personal Support Workers (PSWs), and residents.

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, observed infection prevention and control practices, reviewed relevant resident health care records, programs, policies and procedures, internal investigation files and employee records.

A finding of non-compliance related to r. 49.(2) of the Ontario Regulations 79/10, identified in this inspection will be issued in concurrent Complaint inspection #2021_624196_0006.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **2 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that a PSW used safe transferring techniques when assisting a resident.

A PSW transferred a resident from their wheelchair into the tub chair with a one person transfer, and from the tub chair into the bathtub, without the assistance of another staff member. The resident required a specialized device for the transfer from the wheelchair to the tub chair and two staff members were required for the placement of the tub chair into the bath tub. The resident was not injured, yet there was a potential for harm as a result of these actions.

The care plan for this resident identified a specific type of assistance by two staff with the use of a specialized device and two person assist with the tub chair into the bathtub.

Sources: CIS report; the LTCH's CIS investigation file; a resident's care plan; policy titled, "Safe Lifting and Care Program, LLP-01-01-01" (effective Dec. 2020); interviews with a CM, and PSWs. [s. 36.] (196) [s. 36.]

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 that ensures staff use safe transferring techniques when assisting a resident , to be implemented voluntarily.

WN #2: 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,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who required continence care products had sufficient changes to remain clean, dry and comfortable.

Two PSW staff had found a resident incontinent. A PSW and an RPN advised that they had not provided continence care for this resident during the shift.

Inspector #577 reviewed the home's investigation file, and the resident's plan of care and identified that the resident required a specific type of assistance with all personal care, including continence care, and wore an incontinence product.

The Inspector identified that this resident was not provided with continence care during the shift.

Sources: CIS report; LTCH's investigation file; interviews with a CM and other relevant staff members; a resident's care plan; progress notes; policies titled, "Continence Management Program, RC-14-01-01" (effective October 2019) and "Care and Comfort Rounds, RC-12-01-06" (effective December 2019). [s. 51. (2) (g)]

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 that ensures a resident has sufficient changes of their continence care products to remain clean, dry and comfortable, to be implemented voluntarily.

Issued on this 11th day of June, 2021

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

Original report signed by the inspector.