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
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Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
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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_0006	004887-21	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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577)

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): May 17 - 21, May 25 - 28, 2021 and offsite on June 1, 2021.

The following intake was inspected upon during this Complaint (CO) Inspection:
-one intake regarding resident care concerns.

Follow Up inspection #2021_624196_0008 and Critical Incident System (CIS) inspection #2021_624196_0007 were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Acting Director of Care (Acting DOC), Clinical Managers (CMs), Registered Nurses (RNs), Registered Dietitian (RD), 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.

A finding of non-compliance related to r. 49.(2) of the Ontario Regulations 79/10, identified in the concurrent Critical Incident inspection #2021_624196_0007, will be issued in this Complaint Inspection report.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

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

- **2 WN(s)**
- **1 VPC(s)**
- **1 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. 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 has failed to ensure that when residents had fallen, the residents were assessed and that where the condition or circumstances of the residents required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

As part of the post falls assessment, the "Clinical Monitoring Record" was to be completed. The "Clinical Monitoring Record" indicated that staff were to complete vital signs, neuro vital signs, pain assessments, and monitor for cognitive changes after a fall with suspected head injury or the fall was unwitnessed, every hour for four hours, and every eight hours for 72 hours.

a) A Critical Incident System (CIS) report was received by the Director, related to a resident who had two falls on the same date, and with the second fall, the resident had an injury and they were sent to the hospital two days later.

The pain and cognitive assessments were not completed after the resident’s second fall with injury.

b) A CIS report was received by the Director related to a resident who had a fall and had an injury.

The pain and cognitive assessments were not completed after the resident’s fall.

There was an actual risk when the resident assessments were not completed in the Clinical Monitoring Record, as required.

Sources: Two CIS reports submitted to the Director; interviews with Clinical Managers and other staff; two resident's progress notes, care plans, Clinical Monitoring Records and post-fall assessments; policy titled, "Fall Prevention and Management Program. RC-15-01-01" (effective April, 2021). [s. 49. (2)]

2. A complaint was received by the Director regarding care concerns for a resident which included two falls, one of the falls resulted in an injury and hospitalization.

The "Clinical Monitoring Record" for the unwitnessed fall and the witnessed fall, had not been completed in entirety.

The Clinical Monitoring Records for both falls had not indicated that the resident's pain had been assessed; the Glascow score was not totaled; and additional areas did not have vital signs or neurological vital signs completed at the required intervals. The record for the unwitnessed fall indicated the resident was in an activity of daily living at a specific time and the assessment had not been completed. In the following hour, the resident had a medical event and was transferred to hospital and diagnosed with a specific medical condition.

There was actual harm when the resident assessments were not completed in the Clinical Monitoring Record, as required.

Sources: Written complaint to the Director; interview with a Clinical Manager, and the Assistant Administrator; a resident's care plans, progress notes, post fall assessments and Clinical Monitoring Records. [s. 49. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 a resident who had an area of impaired skin integrity, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

A resident returned from hospital and had an area of impaired skin integrity. The physician's orders from this date, included an order for a specialized device to assist with this area of impaired skin integrity.

An RPN submitted a requisition for the specialized device almost 25 days after the resident returned from the hospital and the device was put in place the following day.

The resident was not provided with the specialized device at the time it had been ordered by the physician. This action had the potential of causing further skin breakdown as the resident was assessed with impaired skin integrity upon return from the hospital.

Sources: Written complaint to the Director; interview with the complainant, an RPN, a CM, and various other staff members; review of a resident's health care records including progress notes, physician's orders, and impaired skin integrity wound records. [s. 50. (2) (b) (ii)]

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 residents who had an area of impaired skin integrity, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, to be implemented voluntarily.

Issued on this 11th day of June, 2021

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LAUREN TENHUNEN (196), DEBBIE WARPULA (577)
Inspection No. / No de l’inspection :	2021_624196_0006
Log No. / No de registre :	004887-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 10, 2021
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, Thunder Bay, ON, P7B-5G7
LTC Home / Foyer de SLD :	Hogarth Riverview Manor 300 Lillie Street, Thunder Bay, ON, P7C-4Y7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Jonathon Riabov

To St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with s. 49. (2) of the Ontario Regulation 79/10.

Specifically the licensee must:

- ensure that the "Clinical Monitoring Record" is completed as required, after each fall sustained by the residents;

- retrain RPNs on the home's policy, "Fall Prevention and Management Program, RC-15-01-01", ensuring that training related to the "Clinical Monitoring Record" as part of the post fall assessments, included the frequency of pain and cognitive assessments as required; and

- maintain a record of the retraining, what the training entailed, who completed the training and when the training was completed.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that when residents had fallen, the residents were assessed and that where the condition or circumstances of the residents required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

As part of the post falls assessment, the "Clinical Monitoring Record" was to be completed. The "Clinical Monitoring Record" indicated that staff were to complete vital signs, neuro vital signs, pain assessments, and monitor for cognitive changes after a fall with suspected head injury or the fall was

unwitnessed, every hour for four hours, and every eight hours for 72 hours.

a) A Critical Incident System (CIS) report was received by the Director, related to a resident who had two falls on the same date, and with the second fall, the resident had an injury and they were sent to the hospital two days later.

The pain and cognitive assessments were not completed after the resident's second fall with injury.

b) A CIS report was received by the Director related to a resident who had a fall and had an injury.

The pain and cognitive assessments were not completed after the resident's fall.

There was an actual risk when the resident assessments were not completed in the Clinical Monitoring Record, as required.

Sources: Two CIS reports submitted to the Director; interviews with Clinical Managers and other staff; two resident's progress notes, care plans, Clinical Monitoring Records and post-fall assessments; policy titled, "Fall Prevention and Management Program. RC-15-01-01" (effective April, 2021). [s. 49. (2)]

2. A complaint was received by the Director regarding care concerns for a resident which included two falls, one of the falls resulted in an injury and hospitalization.

The "Clinical Monitoring Record" for the unwitnessed fall and the witnessed fall, had not been completed in entirety.

The Clinical Monitoring Records for both falls had not indicated that the resident's pain had been assessed; the Glascow score was not totaled; and additional areas did not have vital signs or neurological vital signs completed at the required intervals. The record for the unwitnessed fall indicated the resident was in an activity of daily living at a specific time and the assessment had not been completed. In the following hour, the resident had a medical event and was transferred to hospital and diagnosed with a specific medical condition.

There was actual harm when the resident assessments were not completed in the Clinical Monitoring Record, as required.

Sources: Written complaint to the Director; interview with a Clinical Manager, and the Assistant Administrator; a resident's care plans, progress notes, post fall assessments and Clinical Monitoring Records. [s. 49. (2)]

An order was made by taking the following factors into account:

Severity: There was actual harm. Three residents had falls, and the "Clinical Monitoring Record" was not consistently completed after each fall, which indicated the residents were not monitored for pain, vital signs, neurological vital signs, or cognitive changes; as per the home's falls program, after each fall.

Scope: The scope of this non-compliance was widespread because a "Clinical Monitoring Record", after each fall, was not completed for three of the three residents reviewed during this inspection.

Compliance History: Seven Written Notifications (WNs), three Voluntary Plan of Corrections (VPCs), and one Compliance Order (CO), had been issued to the home in the previous 36 months, related to this same section of legislation. (196)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 30, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

Service Area Office /
Bureau régional de services : Sudbury Service Area Office