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
Feb 4, 2022	2022_914196_0003	020999-21	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), MELISSA HAMILTON (693)

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 24 to 28, and 31, 2022.

The following intake was inspected on during this Complaint inspection:
-one intake related to resident care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers (CMs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a substitute decision-maker (SDM) and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed Infection Prevention and Control (IPAC) practices, reviewed relevant health care records, reviewed the home's internal investigation notes, and reviewed licensee policies and procedures.

Critical Incident System (CIS) inspection #2022_914196_0004 was inspected concurrently with the Complaint inspection.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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)**

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that an RN and an RPN collaborated with a physician in the care of a resident.

A resident experienced a significant change in their health status. An RN and an RPN assessed the resident multiple times over a specific time period, and did not observe any improvement in their condition. The RPN stated that the resident had a specific indicator that was a concern throughout the time they were being assessed, and the physician was not notified.The RPN indicated the physician was not notified, until the resident's SDM requested the resident be sent to hospital, after a specific time period in which the resident exhibited a significant change in their health status.

A review of the home's investigation, policy, and an interview with a CM identified that the RN and the RPN, should have contacted the physician or Nurse Practitioner (NP) for this resident, when they had a specific indicator that was a concern and a significant change to their health status.

Sources: A complaint submitted to the Director, a Critical Incident System (CIS) report, resident's progress notes, LTCH's policy titled, "Plan of Care, LRC-05-01-01" (dated, June 2021), LTCH's investigation file, interviews with an RPN, a CM, and other relevant staff members. [s. 6. (4) (a)]

2. The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident experienced a significant change in their health status. An RN and an RPN assessed the resident multiple times over a specific time period and did not observe any improvement in their condition, at which time they informed the resident's SDM, who came to the home and requested the resident be sent to hospital.

A review of the home's investigation, policy, and an interview with a CM identified that the RN and RPN, should have contacted the resident's SDM of their significant change in a timely manner.

Sources: A complaint submitted to the Director, a CIS report, resident's progress notes, LTCH's policy titled, "Notification of Family/Substitute Decision-Maker, LRC-11-01-06" (dated, June 2021), LTCH's investigation file, interviews with an RPN, a CM, and other relevant staff members. [s. 6. (5)]

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 and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other and that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 4th day of February, 2022

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

Original report signed by the inspector.