Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
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Original Public Report

Report Issue Date: June 23, 2023

Inspection Number: 2023-1407-0004

Inspection Type:
Complaint
Critical Incident System

Licensee: St. Joseph's Care Group

Long Term Care Home and City: Hogarth Riverview Manor, Thunder Bay

Lead Inspector	**Inspector Digital Signature**
Lauren Tenhunen (196)	Lauren Tenhunen Digitally signed by Lauren Tenhunen Date: 2023.07.10 10:58:02 -04'00'

Additional Inspector(s)
Christopher Amonson (721027)
Jessamyn Spidel (000697)
Eva Namysl (000696)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 24-28, 2023; and May 1, 2, 2023.
The inspection occurred offsite on the following date: May 3, 2023.

The following intakes were inspected:
- One intake related to fall prevention;
- Two intakes related to the provision of care;
- One intake related to medication management;
- One intake related to an incident of resident-to-resident physical abuse;
- Two intakes related to an allegation of staff to resident neglect;
- One intake related to an unexpected death;
- One intake related to a resident fall with injury; and
- One intake related to an allegation of staff to resident physical abuse.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (8)

The licensee failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the residents' plan of care and had convenient and immediate access to it.

A resident had an assigned staff member, that provided a specified intervention. The plan of care binder which the assigned staff member referred to daily, did not include the resident's current care plan or up-to-date recommendations. Interviews with the assigned staff member, indicated they utilized this binder as the primary source of information for this resident. The Clinical Manager (CM) confirmed the staff working with this resident should have the most relevant and up to date information.

Before conclusion of inspection, an inspector observed the plan of care binder which the assigned staff member utilized when providing a specified intervention. The binder was updated with the resident's current care plan, and with the most current recommendations.

Sources: Observations of the assigned staff member and a resident interactions; Record reviews of a resident's health care records, plan of care binder utilized by the assigned staff member, and Point Click Care (PCC); and interviews with the assigned staff members and a CM.

Date Remedy Implemented: May 2, 2023. [000696]

WRITTEN NOTIFICATION: Policy

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to ensure that the nutritional care and dietary services program was implemented and complied with.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee shall develop and implement policies and procedures related to nutritional care, dietary services and hydration and they must be complied with.

A resident was documented as having a significant decrease in weight from the month before. A concern was expressed to staff regarding this resident's inadequate nutrition and decreased weight. The resident was then seen by a registered dietitian (RD) to address the concern.

Review of the resident's health record indicated that this resident had a weight loss of a significant amount over an approximate one month time period. According to the home's policy, and interviews with staff, when a resident had a significant change in weight of a specific amount or greater, it must be communicated to the RD through the process of a referral by registered staff. The RD confirmed they had not received a referral from the staff for the resident to be seen by a dietitian when the weight loss was first identified.

When registered staff failed to submit a referral to the RD for a significant change in weight for this resident, the resident was put at low risk by delaying the process of identifying changes in the resident's condition and implementing the required interventions.

Sources: A resident's health records; LTC home's policy titled "Height and Weight Monitoring: RC-18-01-06" (updated March 2022); LTC home's internal documents; and interviews with staff. [196]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee had failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Rationale and Summary
A resident had fallen when assisted with an activity of daily living (ADL) by a Personal Support Worker (PSW).

The resident's plan of care identified conflicting information about the type of assistance required for the specified ADL.

There was low impact to this resident as no injury occurred as a result of the fall incident but actual risk, as the staff and others involved in the different aspects of care had not collaborated with each other, in the development and implementation of the plan of care.

Sources: Review of a CI report ; the home's investigation file; care plan in effect at the time of the fall; progress notes post fall; Physiotherapy quarterly assessment; PCC ADLs; Interviews with PSWs, Registered Practical Nurse (RPN), Registered Nurse (RN), a CM, Director of Care (DOC), and the Assistant Administrator. [196]

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

1) The licensee has failed to ensure that a resident was not abused by staff.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as:
"(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary
An RPN treated a resident in an inappropriate manner, which resulted in the resident sustaining injuries.

The resident had strategies in place which the RPN did not follow at the time of the incident. The LTC home's investigation concluded that the allegation of abuse was founded.

The incident of abuse had a low level of impact to the resident resulting in injury however the resident's fall after being treated in an inappropriate manner by staff, posed a moderate level of risk.

Sources: CI; a resident's health records; LTC home's investigation file; LTC home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program: RC-02-01-01" (updated April 2022); and interviews with staff. [721027]

2) The licensee failed to protect a resident from neglect.

Rationale and Summary
Section 7 of the Ontario Regulation 246/22 defines neglect as, “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

Over an extensive period of time, a resident was positioned in a specialized chair and was not provided with repositioning, hydration, or continence care.

The progress notes and electronic Treatment Administration Records (eTAR) indicated that this resident had developed and required treatment for an area of impaired skin integrity as a result of this incident. Further review of the health care records also determined there was no documentation of the required checks, monitoring, and repositioning of the chair.

A CM confirmed that staff had not provided care to this resident during the identified time period. The home's investigation had determined that two staff members had failed to provide the required care for the resident.

There was a moderate impact to this resident as they developed an area of impaired skin integrity and had experienced actual harm as a result of not having been provided with the required care.

Sources: Review of CI report; the home's investigation file, which included letters of discipline to staff involved; homes' policies titled, "Zero Tolerance of Resident Abuse and Neglect Program" RC-02-01-01, care plan in effect at the time of the resident's admission; progress notes; wound assessment documents; hard copy of resident’s health care records; and interviews with PSWs, RPN and a CM. [196