Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public	
Name of Inspector:	Rose-Marie Farwell	**Inspector ID #**	122
Log #:	S-00323		
Inspection Report #:	2010_122_2923_21Sep140842		
Type of Inspection:	Complaint		
Date of Inspection:	September 21, 2010		
Licensee:	St. Joseph's Care Group		
LTC Home:	Hogarth Riverview Manor		
Name of Administrator:	Paulina Chow		

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

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA 2007, S.O. 2007, c.8, s.6(7). The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Order:

- **The licensee must ensure that all residents are provided with care as set out in their respective plans of care.**

Grounds:

1. The resident's plan of care contains specific directions regarding toileting of the resident on the commode and transfer by mechanical lift. Other components of the plan of care which are related to all aspects of care delivery for the resident identify and include the following: the resident's preference of following established routines related to bathing, bowel and other care needs; that staff are to be aware of all care routines; and the importance of delivering care to the resident in a consistent manner. It was reported to the Inspector by one RN, two RPN's and one PSW that they and/or other members of the care team who provide direct care to the resident have deviated from the routines and directions contained in the resident's plan of care including interventions related to

falls/balance and toileting/toileting routine.

This order must be complied with by:	Immediate

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA 2007, S.O. 2007, c.8, s.6(1)(c). Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Order:

- **The licensee must ensure that the plan of care for each resident sets out clear directions to staff and others who provide direct care to the residents.**

Grounds:

1. One intervention written in the resident's plan of care identifies that staff are never to leave the resident unattended while the resident is on the toilet. A separate component of the plan of care related to toileting identifies that the resident prefers to be left alone on the commode and further directs staff to ask the resident each time if this continues to be their preference. It was reported to the inspector by one RN that members of the nursing team who provide direct care to the resident do stay in the room while the resident is toileted on the commode. It was reported to the inspector by two RPN's that they; and other members of the nursing team, do not stay with the resident during toileting of the resident on the commode. Directions in the plan of care regarding toileting of the resident are contradictory and are not clear to staff who provide direct care to the resident.

2. The resident's plan of care directs staff to "avoid positive reinforcement of negative behaviours". No clear directions are set out in this component of the plan of care regarding the execution of this intervention.

3. The resident's plan of care contains numerous references and directions regarding bed rail position and bed height. These directions are spread among several, separate components of the plan of care (i.e. Bed Mobility, Falls/Balance, Aids to Mobility) and do not provide clear direction to staff and others who provide direct care to the resident. On September 21st, 2010 at 1450 hrs the inspector observed the resident in bed with half bedrails up on both sides of the bed. The bed was in the lowest position and the resident's wheel chair was placed on an angle beside a mobility aid. On September 23rd, 2010 at 1100 hrs the inspector observed the same resident in their respective room, seated in a wheelchair. The resident's bed was in the highest position with all bedrails up.

This order must be complied with by:		Immediate	
Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA 2007, S.O. 2007, c.8, 6(8). The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Order:

- **The licensee must ensure that staff and others providing direct care to residents are kept aware of all information contained in the plan of care which is relevant to their respective roles and responsibilities in the care delivery process to each resident and will further ensure that access to the above stated information is both convenient and immediate.**

Grounds:

1. The resident's plan of care identifies that the resident requires a one person physical assist with transfers in and out of bed. It also identifies that transfers of the resident may require an additional staff member to assist dependant on the resident's physical/mental status at the time of transfer. The plan identifies a mobility aid that the resident may use to assist with their transfers and also identifies that the resident is to be encouraged to seek assistance with all their transfers. However; it was reported to the inspector by one PSW that the resident was an independent transfer between bed and wheel chair.

2. The resident's plan of care contains numerous references to the use of bedrails and bed height position. These directions are spread among multiple components of the plan of care (i.e. Bed Mobility, Falls/Balance, Aids to Mobility). This format does not facilitate convenient and immediate access to all the information contained in the plan of care which is required by staff to meet the resident's care needs.

This order must be complied with by:	Immediate

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 12th day of October, 2010.	
Signature of Inspector:	R. Farwell
Name of Inspector:	Rose-Marie Farwell
Service Area Office:	Sudbury

Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
Sudbury ON P3E 6A5

Telephone: 705-564-3130
Facsimile: 705-564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
Sudbury ON P3E 6A5

Téléphone: 705-564-3130
Télécopieur: 705-564-3133

☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
September 21, 2010	2010_122_2923_21Sep140842	Complaint Log # S-00323

Licensee/Titulaire
St. Joseph's Care Group, 35 N. Algoma St., P.O. Box 3251 Thunder Bay, ON P7B 5G7
Fax: 807-345-4994

Long-Term Care Home/Foyer de soins de longue durée
Hogarth Riverview Manor, 300 Lillie St. North, Thunder Bay, ON P7C 4Y7
Fax: 807-623-4520

Name of Inspector(s)/Nom de l'inspecteur(s)
Rose-Marie Farwell,#122

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an anonymous complaint inspection related to resident care.

During the course of the inspection, the inspector spoke with: 1 Registered Nurse (RN), 2 Registered Practical Nurses (RPN), 1 Personal Support Worker (PSW), the RAI Coordinator, the Staffing Coordinator, the Clinical Care Coordinator and 1of 2 residents named in the complaint.

During the course of the inspection the inspector: reviewed resident health care records and observed staff providing care to the residents associated with this complaint.

The following Inspection Protocols were used during this inspection:

- Continence Care and Bowel Management
- Responsive Behaviors
- Falls Prevention

Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
3 CO: CO # 001, # 002, # 003

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(7). The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Findings:

1. The resident's plan of care contains specific directions regarding toileting of the resident on the commode and transfer by mechanical lift. Other components of the plan of care which are related to all aspects of care delivery for the resident identify and include the following: the resident's preference of following established routines related to bathing, bowel and other care needs; that staff are to be aware of all care routines; and the importance of delivering care to the resident in a consistent manner. It was reported to the Inspector by one RN, two RPN's and one PSW that they and/or other members of the care team who provide direct care to the resident have deviated from the routines and directions contained in the resident's plan of care including interventions related to falls/balance and toileting/toileting routine.

Inspector ID #:	122

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(1). Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. One intervention written in the resident's plan of care identifies that staff are never to leave the resident unattended while the resident is on the toilet. A separate component of the plan of care related to toileting identifies that the resident prefers to be left alone on the commode and further directs staff to ask the resident each time if this continues to be their preference. It was reported to the inspector by one RN that members of the nursing team who provide direct care to the resident do stay in the room while the resident is toileted on the commode. It was reported to the inspector by two RPN's that they; and other members of the nursing team, do not stay with the resident during toileting

of the resident on the commode. Directions in the plan of care regarding toileting of the resident are contradictory and are not clear to staff who provide direct care to the resident.

2. The resident's plan of care directs staff to "avoid positive reinforcement of negative behaviours". No clear directions are set out in this component of the plan of care regarding the execution of this intervention.

3. The resident's plan of care contains numerous references and directions regarding bed rail position and bed height. These directions are spread among several, separate components of the plan of care (i.e. Bed Mobility, Falls/Balance, Aids to Mobility) and do not provide clear direction to staff and others who provide direct care to the resident. On September 21st, 2010 at 1450 hrs the inspector observed the resident in bed with half bedrails up on both sides of the bed. The bed was in the lowest position and the resident's wheel chair was placed on an angle beside a mobility aid. On September 23rd, 2010 at 1100 hrs the inspector observed the same resident in their respective room, seated in a wheelchair. The resident's bed was in the highest position with all bedrails up.

Inspector ID #:	122

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #3: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, 6(8). The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Findings:

1. The resident's plan of care identifies that the resident requires a one person physical assist with transfers in and out of bed. It also identifies that transfers of the resident may require an additional staff member to assist dependant on the resident's physical/mental status at the time of transfer. The plan identifies a mobility aid that the resident may use to assist with their transfers and also identifies that the resident is to be encouraged to seek assistance with all their transfers. However; it was reported to the inspector by one PSW that the resident was an independent transfer between bed and wheel chair.

2. The resident's plan of care contains numerous references to the use of bedrails and bed height position. These directions are spread among multiple components of the plan of care (i.e. Bed Mobility, Falls/Balance, Aids to Mobility). This format does not facilitate convenient and immediate access to all the information contained in the plan of care which is required by staff to meet the resident's care needs.

Inspector ID #:	122

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

Signature of Licensee or Representative of Licensee	**Signature of Health System Accountability and Performance Division**

Signature du Titulaire du représentant désigné	**representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** October 15, 2010