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

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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
Jan 6, 2022	2021_768693_0026	015789-21, 018364-21, 018381-21, 018568-21, 019151-21, 019212-21, 019393-21	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

MELISSA HAMILTON (693), CHRISTOPHER AMONSON (721027)

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): December 6 to 10, and 13 to 15, 2021.

The following intakes were inspected on during this Critical Incident System (CIS) inspection:

-one intake, related to a resident injury;
-three intakes, related to falls;
-one intake, related to physical abuse of a resident;
-two intakes, related to improper care of a resident; and
-one intake, related to improper care of a resident and transfer to a hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers (CMs), Registered Nurse Best Practice Coordinator (RN Best Practice Coordinator), Infection Prevention and Control Practitioner (IPAC Practitioner), Resident Assessment Instrument Coordinators (RAI Coordinators), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Home Workers (RHWs) a High-Touch Surface Housekeeper, a Janitor, 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.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

4 WN(s)
3 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1.The licensee has failed to ensure that a Registered Nurse (RN) and a Registered Practical Nurse (RPN) collaborated with each other in the care of a resident.

During a shift, an RN and RPN assessed a resident, and observed abnormalities. The RN indicated that the RPN stated they would check the resident’s assessment again with an intervention and call them if there were any concerns, and the RPN indicated that the RN stated they would be back to check on the resident.

The resident exhibited pain throughout the shift, and the RPN gave them a pain medication, which they reported was somewhat effective, but "not really" for the resident’s pain. The RPN stated that they normally would have called the RN or physician, if a resident had increased pain that could not be managed, but since the RN had indicated they would come back, the RPN did not call the RN or physician.

There was a lack of communication amongst the nurses, the RPN did not call the RN or Physician to communicate their concerns with the resident throughout the shift, and the RN did not come back to assess the resident until a number of hours later. When the RN assessed the resident, they indicated that the resident’s condition had worsened, and they were in pain.

The resident was sent to the hospital and required surgical intervention.

A Clinical Manager (CM) indicated the RN and RPN should have collaborated on the care of the resident; the RPN should have called the RN back to assess the resident at a reasonable time, when they found the pain medication was not effective for the resident's pain or called the physician, and the RN should have assessed the resident sooner, and then contacted the physician. The CM indicated that the lack of collaboration caused a delay in the resident getting to the hospital.

Sources: a CIS report; progress notes for a resident; a resident's care pan; LTCH's investigation file; policy titled," Plan of Care" (dated, June 2021); interviews with a CM, RN, and RPN. [s. 6. (4) (a)]

2.The licensee has failed to ensure that a resident was transferred by a Personal Support Worker (PSW) as per their plan of care.

A PSW transferred a resident, utilizing a mechanical lift without assistance from a second staff member.

The resident's care plan indicated that they required the use of a mechanical lift for transferring; and two staff members were required to complete the transfer.

A CM indicated that the PSW completed the mechanical lift transfer of a resident on their own, and that two staff were required as per the resident's plan of care and the home's policy. The CM stated that actual risk occurred as a result of the transfer.

Sources: a CIS report; a resident's care plan; LTCH's investigation file; policy titled, "Mechanical Lifts Procedure, LLP-01-01-03" (dated, December 2020); interviews with CM #105 and other relevant staff members. [s. 6. (7)]

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 to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was not abused by a PSW.

O. Reg. 79/10, s. 2, defined physical abuse as the use of physical force by anyone other than a resident that caused physical injury or pain.

A PSW attempted to assist a resident with personal care. During the staff to resident interaction, the resident became resistive to care. The PSW tried to manage the resident's behaviours, and their actions resulted in a injury to the resident.

A CM indicated that the incident between the resident and PSW, was physical abuse, and harm occurred to the resident.

Sources: a CIS report; progress notes for a resident; a resident's plan of care; an employee file; LTCH's investigation file; policy titled, "Zero Tolerance of Resident Abuse and Neglect Program, LRC-02-01-01" (dated, June 2021); interviews with a CM, PSW, and other relevant staff members. [s. 19. (1)]

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 to ensure that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: 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 and a Resident Home Worker (RHW) used safe transferring techniques when assisting a resident.

The PSW and RHW transferred a resident using a mechanical lift. In the process of transferring the resident, one of the straps on the required sling was not attached to the mechanical lift and neither of the staff had done the six point checklist to ensure the lift was safe to complete. This resulted in the resident sliding out of the sling and they sustained minor injuries.

The “Mechanical Lifts Procedure” policy stated that staff were to re-check the applications of the loops to the mechanical lifting device after initially applying them. Additionally, that both staff members were to complete the six point checklist attached to the lift.

The home's investigation identified that the PSW and RHW completed an improper transfer of the resident.

Sources: a CIS report; the LTCH’s investigation file; a resident’s progress notes and care plan; policy titled, "Mechanical Lifts Procedure, LLP-01-01-03" (dated, December 2020); interviews with a RHW, PSW and Registered Nurse (RN) Best Practice Coordinator. [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 to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that physical abuse of a resident was immediately reported to the Director.

An incident occurred between a resident and a PSW, which resulted in harm to the resident.

See WN #2, finding #1, for further details.

A CM, indicated that the incident was not immediately reported to the Director.

Sources: a CIS report; progress notes for a resident ; a resident's plan of care; an employee file; LTCH's investigation file; policy titled, "Zero Tolerance of Resident Abuse and Neglect Program, LRC-02-01-01" (dated, June 2021); policy titled, "Critical Incident Reporting (ON), LRC-09-01-06" (dated, June 2021); interviews with a CM, and other relevant staff members. [s. 24. (1)]

Issued on this 6th day of January, 2022

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

Original report signed by the inspector.