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
Mar 31, 2022	2022_945027_0006	004594-22	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

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): March 28 - 30, 2022

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

-one intake related to an improper transfer.

Inspector #693 attended this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Manager, Infection Prevention and Control Lead (IPAC Lead), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), a High-Touch Surface Housekeeper, and residents.

The Inspector 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:
Infection Prevention and Control
Personal Support Services

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 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 :

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

During a shift, a PSW requested assistance transferring a resident in their room. The PSW was instructed by an RPN to wait until additional staff were available to assist with the transfer. After the RPN left the room, the PSW proceeded to transfer the resident without a second staff to assist, despite being directed to wait. This resulted in an unsafe transfer which put the resident and staff at risk for injury.

The “Mechanical Lifts Procedure” policy stated that two people were required at all times for mechanical lifts. Additionally, both staff members were to complete a “6 Point Checklist” which included both staff being ready and positioned correctly to complete the lift.

The resident’s most recent physiotherapy assessment and care plan indicated that the resident required an identified level of assistance for all transfers.

The home’s investigation report identified that the PSW completed an improper transfer of the resident.

Sources: a CIS report; the LTCH’s investigation file; resident’ progress notes, assessments and care plan; “Mechanical Lifts Procedure” LLP-01-01-03 (Updated December 2021); interviews with Clinical Manager and other relevant staff members.

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.

Issued on this 31st day of March, 2022

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

Original report signed by the inspector.