Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Oct 31, 2019	2019_671684_0036	013881-19, 014473-19, 015641-19, 016402-19, 017067-19, 018098-19, 019338-19	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

SHELLEY MURPHY (684), AMY GEAUVREAU (642), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), TRACY MUCHMAKER (690)

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): October 21-25, 2019.

The following intakes were inspected upon during this Critical Incident System Inspection:

-Six Logs related to resident to resident abuse, and;
-One Log related to improper transfers.

Follow Up inspection #2019_671684_0035 and Complaint inspection #2019_671684_0037 were conducted concurrently with this Critical Incident System inspection.

PLEASE NOTE: Non-compliance of a Compliance Order (CO) related to r. 53 (4) b of the O. Reg 79/10, were identified in this inspection and have been issued in Inspection Report #2019_671684_0035, which was conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance of a Written Notification (WN) related to r. 30(1)(2) of the O. Reg 79/10, and; non-compliance of a Voluntary Plan of Correction (VPC) related s. 6(7) of the LTCHA 2007 were identified in this inspection and have been issued in Inspection Report #2019_671684_0037, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Regional Director, Administrator, Clinical Managers (CM), Physio Therapist (PT), Psychogeriatric Resource Consultant (PRC), Social Worker (SW), Therapeutic Recreationist (TR), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Contractors, residents and families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, complaint records, as well as relevant policies and procedures.

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

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

2 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A Critical Incident (CI) report was submitted to the Director for improper/incompetent treatment of resident #005 that resulted in harm or risk to a resident.

a) During a review of the care plan in place at the time of the incident for resident #005 by Inspector #684, it noted interventions which advised staff of the amount of assistance the resident required for transferring. The current resident care plan was reviewed and stated the amount of assistance required for care.

Inspector #684 reviewed a progress note written by the Physiotherapist (PT) prior to the incident which stated the amount of assistance the resident required and the type of mobility aid to use, as well as a PRN [As required] intervention. The most recent PT note stated the amount of assistance required and a prn intervention.

Inspector #684 spoke to Personal Support Worker (PSW) #103 and asked how they knew how much assistance was required for a resident. The PSW stated they looked in the care plan and it would give a description. The Inspector asked if as required information would be identified there as well. PSW stated that prn information would also be noted in the care plan, as well as on the kardex.

Inspector #684 interviewed Registered Practical Nurse (RPN) #104 who stated that the

current care plan for resident #005 said the amount of assistance they required. RPN #104 stated the prn intervention should be noted in the care plan, they confirmed this was not noted in the care plan.

Inspector #684 reviewed the home's policy titled "Care Planning", RC-05-01-01, last updated April 2017, which stated "Ensure the care plan is revised when appropriate to reflect the resident's current needs, based on evaluation of progress towards goals, response to care and treatment; and significant changes in the resident's status".

Inspector #684 reviewed the progress notes written by the PT with Clinical Manager (CM) #101; the notes stated the amount of assistance that resident #005 required as well as a prn intervention. Inspector #684 asked if the prn interventions should have been noted in the resident care plan. CM #101 confirmed that the care plan should have reflected the prn intervention.

b)Inspector #684 reviewed the progress notes from the date of the incident for resident #005 which indicated interventions that were in place and being used for the resident.

Inspector #684 interviewed PSW #102 regarding resident #005's use of a specified intervention. PSW #102 stated the specified intervention would be noted in the resident's care plan or Kardex. PSW #102 reviewed the kardex for resident #005 and could not locate where it stated the intervention that was being used. PSW #102 confirmed that resident #005 was currently using a specified intervention.

Together, CM#101 and Inspector #684 reviewed the current care plan for resident #005, the CM stated the specified intervention should have been noted in the care plan and it was not. [s. 6. (10) (b)]

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 ensuring that the resident is reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 staff used safe transferring and positioning devices or techniques when assisting residents.

Inspector #684 reviewed a CI report submitted to the Director for improper or incompetent care of resident #005. The CI report stated that the PSW did not follow direction of the registered staff while providing care to resident #005 causing an incident.

Inspector #684 reviewed the progress notes for resident #005 which indicated the circumstance which lead up to the incident, RPN gave a directive to use a specified intervention when providing care to the resident.

Inspector #684 reviewed the home's investigation notes which indicated that RPN #125 had told all PSWs, including PSW #124, that they were to use a specified intervention to provide care to resident #005. PSW #124, agreed that the RPN told them about the specified intervention for resident #005 and they chose not to listen.

During an interview with the Administrator and Inspector #684, the Administrator stated that the PSW staff should have followed the direction provided by the registered staff member for the care of resident #005. [s. 36.]

Issued on this 14th day of November, 2019

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

Original report signed by the inspector.