



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et des
Soins de longue durée**

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

**Health System Accountability and Performance
Division
Performance Improvement and Compliance Branch**
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 9, 2011; Jan 31, Feb 2, 2012	2011_051106_0008	Critical Incident

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251, 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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Clinical Care Coordinator (CCC), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) Conducted a walk-through of all resident home areas and various common areas, observed care provided to residents in the home, reviewed electronic plans of care, reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

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,

(a) the planned care for the resident;

(b) the goals the care is intended to achieve; and

(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 written plan of care for a resident, under the section titled "Falls/Balance", indicates "Bed alarm removed Aug 27/2010" and "use bed alarm". This does not provide clear directions to staff and other who provide direct care to the resident. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (1) (c)] (106)

2. On August 11, 2011, 3 staff members were interviewed regarding fall prevention interventions for a resident, all three told the inspector that bed-side floor mats were used for the resident. During this inspection, inspector 106 observed bed-side floor mats in the resident's room. The resident's plan of care does not indicate the use of bed-side floor mats. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106)

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. On August 11, 2011, the Clinical Care Coordinator told inspector 106 that the home was currently working on developing the written description of the falls prevention and management program. The Licensee failed to ensure that there was a written description of the falls prevention and management program. [O. Reg. 79/10, s. 30 (1) 1] (106)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

- 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.**
- 2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.**
- 3. A missing or unaccounted for controlled substance.**
- 4. An injury in respect of which a person is taken to hospital.**
- 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

- 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.**
- 2. A description of the individuals involved in the incident, including,
 - i. names of any residents involved in the incident,**
 - ii. names of any staff members or other persons who were present at or discovered the incident, and**
 - iii. names of staff members who responded or are responding to the incident.****
- 3. Actions taken in response to the incident, including,
 - i. what care was given or action taken as a result of the incident, and by whom,**
 - ii. whether a physician or registered nurse in the extended class was contacted,**
 - iii. what other authorities were contacted about the incident, if any,**
 - iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and**
 - v. the outcome or current status of the individual or individuals who were involved in the incident.****
- 4. Analysis and follow-up action, including,
 - i. the immediate actions that have been taken to prevent recurrence, and**
 - ii. the long-term actions planned to correct the situation and prevent recurrence.****
- 5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).**

Findings/Faits saillants :

- 1. On October 21, 2010, a resident, sustained injury and was transferred to hospital. This critical incident was not reported to the Director until October 26, 2010. The Licensee failed to inform the Director with in one business day of an injury in respect of which a person is taken to hospital.[O. Reg. 79/10, s. 107 (3)](106)**
- 2. On October 18, 2010, a resident, sustained injury and was transferred to hospital. This critical incident was not reported to the Director until October 26, 2010. The Licensee failed to inform the Director with in one business day of an injury in respect of which a person is taken to hospital.[O. Reg. 79/10, s. 107 (3)](106)**
- 3. On October 18, 2010, a resident fell and was transferred to hospital for assessment. The critical incident report states that a PSW alerted staff that resident was on the floor in her room. The report does not include the name of the PSW who discovered the incident. [O. Reg. 79/10. s. 107 (4) 2 (ii)] (106)**
- 4. On October 15, 2010, a resident, sustained injury and was transferred to hospital. This critical incident was not reported to the Director until October 26, 2010. The Licensee failed to inform the Director with in one business day of an injury in respect of which a person is taken to hospital.[O. Reg. 79/10, s. 107 (3)] (106)**



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Issued on this 2nd day of February, 2012

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

A handwritten signature in black ink, appearing to be "M. J. D.", written within the signature box.