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 prévue le Loi de 2007 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 30, 2016;	2016_246196_0007 (A1)	006316-16	Critical Incident System

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

LAUREN TENHUNEN (196) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for Order #001 was extended to June 22, 2016, at the request of the Licensee.

Issued on this 30 day of June 2016 (A1)

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

Original report signed by the inspector.

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 prévue le Loi de 2007 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 30, 2016;	2016_246196_0007 (A1)	006316-16	Critical Incident System

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

LAUREN TENHUNEN (196) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 17, 18, 19, 20, 21, 24, 29, 30, 31, April 1, 2016.

This Critical Incident Inspection is related to a critical incident report the home submitted regarding abuse/neglect of two residents in the home.

This inspection was conducted concurrently with a Follow up inspection #2016_246196_0006 and a Complaint inspection #2016_246196_0005.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Clinical Manager, Registered Nurses (RN), Registered Dietitian (RD), Manager of Food Services, Food Service Supervisors (FSS), Dietary Aides (DA), Residents and Family Members.

During the course of this inspection, a walkthrough of resident home areas was conducted, interactions between staff members and residents and the provision of care and services to residents were observed, a Critical Incident System report and associated investigation notes were reviewed, the health care records for two residents were reviewed and the various home policies were reviewed.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

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

5 WN(s)
1 VPC(s)
1 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	Legendé 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. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a Registered Dietitian who is a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

During the inspection, interviews were conducted with the Registered Dietitian (RD). They reported that they work onsite at the home two days per week, approximately 60 hours per month and had been focused on the new admissions, family concerns/complaints and referrals from staff.

The RD provided their list of new admissions, the due date and the actual date of completion of the initial nutrition assessment, and included a check mark which identified "care plan developed" and "risk level". The RD went through their list of new admissions and identified which residents had their initial nutrition assessment completed. They confirmed that some of the residents had not had their assessments done, and they may be a high risk nutritionally but this was unknown until assessed.

The list as provided by the RD, was reviewed by the Inspector, and identified that between January 5 and March 2, 2016, there were a total of 255 new admissions to the home. Of those, 69 have had an initial nutritional assessment completed, or 27 per cent of the new resident admissions. 73 per cent of the new resident admissions had not had an initial nutritional assessment completed in the required time period of 14 days, as per O.Reg. 79/10, r. 25.(1)(a).

On March 29, 2016, an interview was conducted with the Food Services Supervisor #126 who reported the home's current census was 370 residents. In order to meet the legislation requirements, the RD would have to be onsite at the home for 185 hours per month based upon this number of residents. [s. 74. (2)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of three meals daily.

On a particular day in March 2016, a Critical Incident System (CIS) report was submitted to the Director for an incident of abuse/neglect which had occurred on a specific day in February 2016. According to the report, resident #002 and resident #003 were not provided with a breakfast meal on a specific day in February 2016.

The health care records for resident #002 were reviewed for information regarding nutritional concerns. The admission nutritional assessment completed by the Registered Dietitian identified this resident as having a specific nutritional risk and a related medical condition which required interventions.

The health care records for resident #003 were reviewed for information regarding nutritional concerns. The admission nutritional assessment completed by the Registered Dietitian identified this resident as having a specific nutritional risk.

On March 17, 2016, an interview was conducted with Clinical Manager #102 regarding the submitted CIS report and the investigation. They reported that the investigation determined that resident #002 and resident #003 had not been assisted into the dining room the morning of the incident and and in turn were not provided with a breakfast meal.

During previous inspection #2016_249196_0002 a WN/VPC was issued, and inspection #2016_264609_0006 a WN was issued to the home specific to this same regulation. [s. 71. (3) (a)]

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 that ensures resident #002 and #003 and all residents, are offered a minimum of three meals daily, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (4) For the purposes of subsection (3), but subject to subsection (5), the minimum number of hours per week shall be calculated as follows: M = A × 8 ÷ 25 where, "M" is the minimum number of hours per week, and "A" is,
(a) if the occupancy of the home is 97 per cent or more, the licensed bed capacity of the home for the week, or O. Reg. 79/10, s. 75 (4).
(b) if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents. O. Reg. 79/10, s. 75 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a nutrition manager was on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. For the purposes of subsection (3), but subject to subsection (5), the minimum number of hours per week shall be calculated as follows: M = A × 8 ÷ 25 where, "M" is the minimum number of hours per week, and "A" is, if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents.

During the inspection, an interview was conducted with Food Service Supervisor (FSS) #126. They reported that the home had two full time FSSs, including themselves and confirmed that the required hours working in the capacity of Nutrition Managers, was not being met. They went on to report that based on the current home census of 370 residents, the requirement was for the FSSs to work a total of 118 hours per week. In addition, they reported that three additional FSSs had been hired to work part time in the home in order to meet the required hours.

During the inspection, an interview was conducted with FSS #127. They reported that they and FSS #126 work 37.5 hours weekly, for a total of approximately 75 hours per week. In addition, they reported that the FSSs complete resident quarterly assessments on those that are a low or moderate nutrition risk and they are behind in quarterly assessments. [s. 75. (4) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

On a particular day in March 2016, a Critical Incident System (CIS) report was submitted to the Director for an incident of abuse/neglect which had occurred on a specific day in February 2016. The report outlined an incident in which two residents of the home, #002 and #003, had not been provided with a breakfast meal and identified that the substitute decision makers (SDM) were notified.

On March 17, 2016, an interview was conducted with Clinical Manager #102. They reported that the SDM of resident #002 was not notified of the incident until approximately two days after the occurrence. They went on to report that the delay in notification of the SDM was that they wanted to wait until the investigation was completed.

The home's procedure titled "Zero tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect - LTC 5-51" with approval date of February 2016, was reviewed for information regarding the notification of the substitute decision maker (SDM). The procedure identified that "the family member of substitute decision maker (SDM), if any, or any other person specified by the resident is notified within 12 hours of becoming aware of the incident of abuser/neglect (alleged, suspected, witnessed, unwitnessed)." [s. 97. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all 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.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, in making a report to the Director under subsection 23 (2) of the Act, the licensee included the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: A description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident.

On a particular day in March 2016, a Critical Incident System (CIS) report was submitted to the Director for an incident for an incident of abuse/neglect which had occurred on a specific day in February 2016. The report identified an incident in which two residents of the home had not been provided with a breakfast meal.

The report was reviewed on March 17, 2016, with Clinical Manager #102 and they confirmed with the Inspector that two staff members, PSW #151 and PSW #152 were not identified on the submitted CIS report, despite being present at the time of the incident's occurrence. [s. 104. (1) 2.]

Issued on this 30 day of June 2016 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LAUREN TENHUNEN (196) - (A1)

Inspection No. / No de l'inspection : 2016_246196_0007 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 006316-16 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jun 30, 2016;(A1)

Licensee / Titulaire de permis : ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251,
THUNDER BAY, ON, P7B-5G7

LTC Home / Foyer de SLD : HOGARTH RIVERVIEW MANOR
300 LILLIE STREET, THUNDER BAY, ON,
P7C-4Y7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Meaghan Sharp

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 # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Order / Ordre :

The licensee shall:

a) develop a plan that will ensure that all resident admissions that are dated January 5, 2016, or after, have an initial nutrition assessment completed by the RD within the required time frame.

b) ensure that there is a Registered Dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

Grounds / Motifs :

1. The licensee failed to ensure that a Registered Dietitian who is a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

On March 24 and April 1, 2016, interviews were conducted with the Registered Dietitian (RD). They reported that they work onsite at the home two days per week, approximately 60 hours per month and had been focused on the new admissions, family concerns/complaints and referrals from staff.

The RD provided their list of new admissions, the due date and the actual date of completion of the initial nutrition assessment, and included a check mark which identified "care plan developed" and "risk level". The RD went through their list of new admissions and identified which residents had their initial nutrition assessment completed. They confirmed that some of the residents had not had their assessments done, and they may be a high risk nutritionally but this was unknown until assessed.

The list as provided by the RD, was reviewed by the Inspector, and identified that between January 5 and March 2, 2016, there were a total of 255 new admissions to the home. Of those, 69 have had an initial nutritional assessment completed, or 27 per cent of the new resident admissions. 73 per cent of the new resident admissions had not had an initial nutritional assessment completed in the required time period of 14 days, as per O.Reg. 79/10, r. 25.(1)(a).

On March 29, 2016, an interview was conducted with the Food Services Supervisor #126 who reported the home's current census was 370 residents. In order to meet the legislation requirements, the RD would have to be onsite at the home for 185 hours per month based upon this number of residents.

The decision to issue this compliance order was based on the scope being widespread, the severity which indicates a minimal risk or potential for actual harm and the compliance history which is one or more unrelated non-compliance in the previous three years. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jun 22, 2016(A1)

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 services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30 day of June 2016 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LAUREN TENHUNEN

Service Area Office / Bureau régional de services : Sudbury