Ontario

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 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
Feb 12, 2019	2019_768693_0004	025087-18, 000981-19	Complaint

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

MELISSA HAMILTON (693), JULIE KUORIKOSKI (621), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 21 to 25, 2019 and January 28 to Feb 1, 2019.

The following intakes were inspected upon during this Complaint inspection:
- One complaint, regarding lack of nursing supervision, responsive behaviours and abuse; and
- one complaint, regarding lack of supervision in the dining room, and improper care.

Critical Incident System (CIS) inspection # 2019_768693_0002 and Follow Up inspection # 2019_768693_0003 were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Clinical Managers (CMs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) Coordinators, Resident Home Workers (RHW), Therapeutic Recreationists, Staff Educator, Staffing Coordinator, complainants, Substitute Decision makers (SDMs), residents and their family members.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, home's internal investigation notes and complaints, staff education records, as well as reviewed numerous licensee policies, procedure and programs.

The following Inspection Protocols were used during this inspection:
Dining Observation
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals.

A complaint was received by the Director on a specified date, that outlined concerns about resident #007's plan of care not being followed as well as concerns that resident #007 had been found in the dining room eating while unsupervised.

During an interview with resident #007's SDM, they stated that on a specified date, while they visited resident #007 they observed them in the dining room eating with their meal plated in front of them, and no staff present in or around the dining room.

During an interview with RPN #100 they stated that all residents should have been supervised while eating and that it was the responsibility of the RPN to ensure that all food was cleared off tables before taking their breaks. RPN #100 stated that when they took their break on a specified date, they thought that all food had been cleared from the dining room. They stated that they received a written warning from a manager for leaving the dining room to take their break on the specified date, while resident #007 was seated in the dining room with food in front of them.

Inspector #693 reviewed the home's complaints binder from a specific year, which included a complaint form from resident #007's SDM for the incident that occurred on a specified date. The home's investigation notes attached to this complaint form indicated that the home's video footage was reviewed and resident #007 was observed to be eating a meal between an identified period of time. The investigation notes indicated that RPN #100 left the dining room at a specific time, and resident #007 continued eating without supervision until their SDM arrived at a later time. The investigation notes indicated that RPN #100 was given a letter of discipline on a specified date, as they had left the dining room on the identified date, after a meal, prior to ensuring that all residents' meals had been cleared from the table.

During an interview with CM #101 they stated that if residents were actively eating a registered staff member needed to be monitoring residents in the dining area. CM #101 stated that they reviewed the home's video surveillance from a specified date, and resident #007 had a plate of food in front of them, while they were unsupervised between an identified period of time. [s. 73. (1) 4.]

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 home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals, to be implemented voluntarily.

Issued on this 20th day of February, 2019

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

Original report signed by the inspector.