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
Jul 3, 2019	2019_740621_0020	011878-19	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

JULIE KUORIKOSKI (621)

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): June 24 - 27, 2019.

The following intake was inspected during this Critical Incident System (CIS) Inspection:
- One intake regarding an unexpected resident death.

During the course of the inspection, the inspector(s) spoke with a Co-Director of Care (CoDOC), a Clinical Manager, the Food Services Manager (FSM), the Registered Dietitian (RD), Registered Nurses (RNs), a Registered Practical Nurse (RPN), Personnel Support Workers (PSWs), and Dietary Aides.

The Inspector also observed the provision of care and services to residents, and reviewed the home's documentation, including relevant resident health care records, staff training, the home's CIS investigation records, and specific licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 30. General requirements

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 30 (1).
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. O. Reg. 79/10, s. 30 (1).
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. O. Reg. 79/10, s. 30 (1).
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. The licensee has failed to ensure that the nutrition care and dietary services programs were evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A Critical Incident System (CIS) report was submitted to the Director on a specific day in June 2019, for an unexpected death of resident #001.

Inspector #621 reviewed the home's investigation notes, which identified that before the incident, resident #001 had ingested a modified texture beverage at a specified time of day, which was obtained from a particular area of the home, at a certain time, by PSW #113.

During an interview with PSWs #101, #106, #107 and #108, they reported to Inspector #621 that modified texture beverages were prepared by the Dietary Aides, and that there

had been issues with a component of the beverages separating out of their mixed state following preparation.

During an interview with Dietary Aide #102, they reported to the Inspector that the home had changed over to a new food service company in June 2019.

During an interview with the Food Services Manager (FSM), they confirmed to Inspector #621 that the home hired the current food services operator as of a specific date in June 2019. When the Inspector inquired as to what program policies were in place related to specific aspects of the nutrition care and dietary services program, the FSM reported that there were no policies or procedures available in the home that addressed the specific areas identified.

Additionally, the FSM reported that the current food service operator had not implemented their own corporate policies, but instead were utilizing the home's former nutrition care and dietary services program policies that were in place prior to the change over in June 2019. Further, the FSM reported that there had been direction given to the former food service operator to implement Extendicare's corporate policies prior to the change over; however, it was confirmed that this had not been done.

When the Inspector inquired as to what specific policies were in place for the nutrition care and food services program at the time of inspection, the FSM was only able to produce three policies. The FSM confirmed that three policies were not the only policies and procedures that would be expected to be in place for their program; that the Extendicare policies for this program area had not been fully implemented at of the time of inspection, and that they had been unable to determine when, if ever, an annual evaluation and update of the nutrition care and dietary services program had occurred in the home.

During an interview with the home's Registered Dietitian (RD), they reported that the last annual review and revision of any nutrition care and dietary services program policies and procedures, to their recollection, occurred in 2016. [s. 30. (1) 3.]

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 nutrition care and dietary services programs is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system, at minimum, provided for preparation of all menu items according to the planned menu.

A Critical Incident System (CIS) report was submitted to the Director on a specific day in June 2019, for an unexpected death of resident #001.

Inspector #621 reviewed the home's investigation notes, which identified that before the incident, resident #001 had ingested a specific modified texture beverage, which was obtained from a particular area of the home, at a certain time, by PSW #113.

The Inspector reviewed the home's planned menu for a specific day in June 2019, which identified that the beverage component of the planned nourishment was to be a particular

product type.

During an interview with Dietary Aide #114, it was confirmed that they had prepared the modified texture beverages for the planned nourishment on the specified day in June 2019, and that they had prepared the beverages using a product different than the one identified on the planned menu. Dietary Aide #114 reported that they did this because either there wasn't any of the specified product available for use, or because they had read the planned menu incorrectly and prepared the beverage option that was meant for another day of the planned menu.

During an interview with the Food Services Manager (FSM), they reported to Inspector #621 that it was their expectation that dietary and food production staff prepared all menu items according to the planned menu. The FSM further identified that if a menu item needed to be changed due to unavailability of a product, it was expected that staff would notify their food services supervisor, and communicate the change to residents and unit staff of the required menu substitution. [s. 72. (2) (d)]

2. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve appearance and food quality.

A Critical Incident System (CIS) report was submitted to the Director on a specific day in June 2019, for an unexpected death of resident #001.

Inspector #621 reviewed the home's investigation notes, which identified that before the incident, resident #001 had ingested a specific modified texture beverage, which was obtained from a particular area of the home, at a certain time, by PSW #113.

The Inspector reviewed resident #001's diet order in effect at the time of the incident, which identified that the resident required a specific type of modified texture beverage, as part of their diet.

During an interview with PSWs #101, #106, #107 and #108, they reported to Inspector #621 that modified texture beverages were prepared by the Dietary Aides, and that there had been issues with a component of the beverages separating out of their mixed state following preparation. The PSWs reported that this happened when the Dietary Aides used a specific method to prepare the beverages.

During an interview with Dietary Aide #114, it was confirmed that they had prepared the modified texture beverages for a particular area of the home on a specified date in June 2019, and that they had prepared the modified texture beverages according to manufacturer's directions, utilizing a specific method.

Inspector #621 reviewed the manufacturer's directions for preparing modified texture beverages, which included recipe information, suggested methods of preparation and shelf life guidelines.

During an interview with the FSM, they reported to Inspector #621 that at a particular time, on a specific date in June 2019, they conducted a follow up of the modified texture beverage products prepared in a certain area of the home, and found a container of a specific modified texture beverage that had been prepared the day prior. They noted that the contents in this container had separated. The FSM was unable to determine whether this was the same beverage provided to resident #001 on the previous evening. They identified to the Inspector that they proceeded to do a sweep of the home and removed any remaining containers of modified thickened beverages that had been prepared. During that sweep, the FSM reported that they found prepared beverages that were labelled with preparation dates that exceeded the manufacturer's shelf life guidelines, which the FSM identified could affect product quality. The FSM reported that when using a specific method for preparing modified texture beverages, it was determined that the Dietary Aide who had prepared the beverages for a specific area of the home, on a specified date, in June 2019, either had not followed the manufacturer's directions for preparation in their entirety, or had not applied enough manual effort to ensure the product was thoroughly mixed. Consequently, the FSM confirmed that they observed modified texture beverage, prepared by food service staff, which had not preserved its appearance and food quality, as would have been expected. [s. 72. (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 to ensure that all food and fluids in the food production system are prepared, stored and served using methods to preserve appearance and food quality, to be implemented voluntarily.

Issued on this 4th day of July, 2019

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

Original report signed by the inspector.