Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

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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
Jan 6, 2021	2020_768693_0028	017012-20, 017013-20, 017772-20, 017773-20, 017774-20, 021536-20, 021538-20, 021539-20, 021540-20	Follow up

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

MELISSA HAMILTON (693), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 7 to 11, 2020, and December 14 to 17, 2020.

The following intakes were inspected on during this Follow Up Inspection:

-an intake, related to CO#001 from inspection #2020_633577_0020, issued pursuant to LTCHA, S.O. 2007, c.8, s. 6. (7);

-an intake, related to CO#004 from inspection #2020_633577_0019, issued pursuant to O.Reg 79/10, s. 213. (4);

-an intake, related to CO#003 from inspection #2020_633577_0019, issued pursuant to O.Reg 79/10, s. 44.;

-an intake, related to CO#001 from inspection #2020_633577_0019, issued pursuant to LTCHA, S.O. 2007, c.8, s. 3. (1);

-an intake, related to CO#001 from inspection #2020_768693_0013, issued pursuant to LTCHA, S.O. 2007, c.8, s. 20. (1);

-an intake, related to CO#002 from inspection #2020_768693_0013, issued pursuant to O.Reg 79/10, s. 36.;

-an intake, related to CO#003 from inspection #2020_768693_0013, issued pursuant to O.Reg 79/10, s. 48. (1);

-an intake, related to CO#001 from inspection #2020_768693_0011, issued pursuant to LTCHA, S.O. 2007, c.8, s. 19. (1); and

-an intake, related to CO#001 from inspection #2020_768693_0012, issued pursuant to LTCHA, S.O. 2007, c.8, s. 24. (1).

Complaint (CO) inspection #2020_768693_0026, and Critical Incident System (CIS) inspection #2020_768693_0027 were conducted concurrently with this Follow Up inspection.

A compliance order related to O. Reg. 79/10, s. 36, identified in concurrent inspection #2020_768693_0027, was issued in this report.

Findings of non-compliance related to section 6. (7) of the Long-Term Care Homes Act, 2007, identified in concurrent inspections #2020_768693_0026, and 2020_768693_0027, were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Extendicare Assist LTC Consultant, Clinical Managers (CMs), Manager of Food Services, Psychogeriatric Resource Consultant, Registered Nurses (RNs), Registered Dietitian (RD), Learning and Telemedicine Facilitator, Resident Assessment Instrument Coordinators (RAI Coordinators), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Home Workers (RHWs),residents, and their family members.

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

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

- **3 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_768693_0011	693
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2020_768693_0013	693
O.Reg 79/10 s. 213. (4)	CO #004	2020_633577_0019	613
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2020_768693_0012	577
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2020_633577_0019	693
O.Reg 79/10 s. 44.	CO #003	2020_633577_0019	693
O.Reg 79/10 s. 48. (1)	CO #003	2020_768693_0013	621
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_633577_0020	577

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. 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 failed to ensure that staff used staff transferring and positioning devices or techniques when assisting a resident.

A CIS report submitted to the Director identified that a resident was transferred without use of a required intervention, which resulted in a fall with injury. A review of the resident's “Transferring” care plan, in effect at the time of the incident, identified that they required assistance for transferring with the required intervention.

During an interview with a PT, they reported that they completed physiotherapy assessments prior to and following the specified fall, and identified the use of an intervention to help with standing and walking. The PT confirmed that it is the PT who makes the determination through assessment for the need of the intervention as part of a resident’s care.

A review of the homes investigation identified that the resident had been improperly transferred, which resulted in a fall with injury to the resident.

During an interview with a CM, they confirmed that a PSW had neglected to complete a proper transfer of the resident, as they failed to use the required intervention at the time of the incident.

Sources: CIS report; homes CIS investigation notes; a resident's care plan; and interviews with PT, CM and other staff. (621) [s. 36.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of a resident were fully respected and promoted: Every resident has the right to be protected from abuse.

A CIS report was submitted to the Director, regarding an allegation of verbal abuse of a resident. The CIS report indicated that a resident, reported to their family member that a PSW called them a derogatory name.

A review of the home's investigation notes, identified interview notes in which a PSW stated to a CM, that they called the resident a derogatory name.

During an interview with a CM, they indicated that a PSW's actions towards the resident, constituted verbal abuse.

Sources: CIS report; LTCH's investigation file; interviews with a CM and other staff; an employee file; training records; and " Zero Tolerance of Resident Abuse and Neglect Program, LRC-02-01-01/ Extendicare RC-02-01-01" (dated December, 2020). [s. 3. (1) 2.]

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 following rights of residents are fully respected and promoted: 2. Every resident has the right to be protected from abuse, to be implemented voluntarily.

WN #3: 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. (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 licensee failed to ensure that nutrition care set out in a resident's plan of care was provided as per the plan.

A Critical Incident System (CIS) report was submitted to the Director for a choking incident, where a resident was found to have been served an incorrect diet texture.

During an interview with an RPN, they reported that during evening snack service, a PSW provided the resident a snack, which was not consistent with the resident's diet.

On review of the snack menu in effect at the time of the incident, the resident was to be offered a appropriate texture snack .On review of the home's investigation notes, the Inspector reviewed a document, which identified that the resident was provided a wrong diet texture for evening snack, which resulted in a choking episode.

During an interview with a CM, they confirmed that a PSW had not reviewed the resident's care plan or snack menu prior to offering the resident the incorrect diet texture during an evening snack, and as a result, care provided to the resident was not provided as per the plan of care.

CO #001 was issued during inspection #2020_633577_0020 pursuant to the Long- Term Care Homes Act (LTCHA), 2007, c.8, s. 6. (7) with a compliance due date of October 29, 2020. As the compliance date was not yet due at the time of this incident, this finding will be issued as a WN to further support the order.

Sources: CIS report; nutrition care plan; planned pureed snack menu; home's investigation notes; and interviews with an RPN, CM, and other staff. (621) [s. 6. (7)]

2. The licensee failed to ensure that nutrition care set out in a resident's plan of care was provided as per the plan.

A complaint submitted to the Director, identified an order for an intervention, which had not been processed and administered to the resident until several weeks later.

During an interview with an RD, they reported that based on a resident's characteristics and a request of a resident's substitute decision maker (SDM) they made an order for an intervention and updated the resident's nutrition care plan. On follow up to the order, the

RD was informed by an RPN that the intervention ordered, had only been added to the medication administration record (MAR) an identified number of days, after it was ordered.

During an interview with a CM, they reported that it was their expectation that registered staff reviewed and processed new orders during each shift, and that the night shift RPN was a further check to ensure all orders for that day were processed. On review of the indicated intervention for a resident, the CM verified that while there were two RPN signatures identifying that a double check had been completed, and the order had been processed on an identified date, that in fact the order had not been added to the MAR and administered to the resident until another date, or 21 days later.

CO #001 was issued during inspection #2020_633577_0020 pursuant to the Long- Term Care Homes Act (LTCHA), 2007, c.8, s. 6. (7) with a compliance due date of October 29, 2020. As the compliance date was not yet due at the time of this incident, this finding will be issued as a WN to further support the order.

Sources: a resident's nutrition care plan; RD’s progress notes; Physician’s Order Sheet for a resident; MARs; and interviews with an RD,CM and other staff. (621) [s. 6. (7)]

Issued on this 15th day of January, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	MELISSA HAMILTON (693), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), LISA MOORE (613)
Inspection No. / No de l’inspection :	2020_768693_0028
Log No. / No de registre :	017012-20, 017013-20, 017772-20, 017773-20, 017774-20, 021536-20, 021538-20, 021539-20, 021540-20
Type of Inspection / Genre d’inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 6, 2021
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, 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 :	Sheila Clark

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2020_768693_0013, CO #002;

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with s. 36. of Ontario Regulation 79/10.

Specifically, the licensee must

- Ensure that staff use safe transferring and positioning devices or techniques, when transferring a resident; and
-Re-educate a PSW on the home's safe transferring policies.

Grounds / Motifs :

1. 1. The licensee failed to ensure that staff used staff transferring and positioning devices or techniques when assisting a resident.

A CIS report submitted to the Director identified that a resident was transferred without use of a required intervention, which resulted in a fall with injury. A review of the resident's "Transferring" care plan, in effect at the time of the incident, identified that they required assistance for transferring with the required intervention.

During an interview with a PT, they reported that they completed physiotherapy assessments prior to and following the specified fall, and identified the use of an intervention to help with standing and walking. The PT confirmed that it is the PT who makes the determination through assessment for the need of the intervention as part of a resident's care.

A review of the homes investigation identified that the resident had been

improperly transferred, which resulted in a fall with injury to the resident.

During an interview with a CM, they confirmed that a PSW had neglected to complete a proper transfer of the resident, as they failed to use the required intervention at the time of the incident.

Sources: CIS report; homes CIS investigation notes; a resident's care plan; and interviews with PT, CM and other staff (621) [s. 36.]

An order was made by taking the following factors into account:

Severity: There was actual harm as the resident had experienced an injury,

Scope: The scope of this non-compliance was isolated, as it affected one resident.

Compliance History: The licensee continues to be in non-compliance with r. 36 of Ontario Regulation 79/10, resulting in a compliance order (CO) being re-issued. CO #002 was issued on August 13, 2020 (inspection #2020_768693_0013) with a compliance due date of October 19, 2020. In the past 36 months, multiple other COs were issued to different sections of the legislation. (693)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 22, 2021

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melissa Hamilton

Service Area Office /
Bureau régional de services : Sudbury Service Area Office