Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: August 2, 2024
Inspection Number: 2024-1218-0002
Inspection Type: Follow up
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
Long Term Care Home and City: Riverview Manor Nursing Home, Peterborough

Lead Inspector The Inspector	Inspector Digital Signature Sharon Connell Digitally signed by Sharon Connell Date: 2024.08.07 13:44:31 -04'00'

Additional Inspector(s) The Inspector

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19 to 21, and 24 to 28, 2024
The inspection occurred offsite on the following date(s): July 2, 2024

The following intake(s) were inspected:

- Follow-up #1 - CO #001/2024-1218-0002, O. Reg. 246/22, s. 79 (1) 4.
- Follow-up #1 - CO #002/2024-1218-0002, O. Reg. 246/22, s. 79 (1) 5.
- Follow-up #1 - CO #003/2024-1218-0002, O. Reg. 246/22, s. 79 (1) 8.
- Follow-up #1 - CO #004/2024-1218-0002, O. Reg. 246/22, s. 140 (2).

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1218-0001 related to O. Reg. 246/22, s. 79 (1) 4. inspected by the Inspector.

Order #004 from Inspection #2024-1218-0001 related to O. Reg. 246/22, s. 140 (2) inspected by the Inspector.

The following previously issued Compliance Order(s) were found NOT to be in compliance:

Order #002 from Inspection #2024-1218-0001 related to O. Reg. 246/22, s. 79 (1) 5. inspected by the Inspector.

Order #003 from Inspection #2024-1218-0001 related to O. Reg. 246/22, s. 79 (1) 8. inspected by the Inspector.

The following Inspection Protocols were used during this inspection:

Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee failed to comply with conditions #3 and #4 of Compliance Order (CO) #002 from inspection #2024-1218-0001, served on March 8, 2024, with a compliance due date of June 5, 2024.

Specifically,
3. Educate nursing and dietary staff on safety measures for serving hot liquids and review the list of residents requiring adaptive aides and interventions for safe handling of hot liquids. Provide a review of the results of the audit to the Registered staff at a meeting including recommendations for improvements.
4. Keep a documented record of the meeting agenda, content, and attendance of the meeting. The documented record is to be posted in an area accessible to nursing and dietary staff and to be made available immediately upon request to the Inspector.

Rationale and Summary:

At the time of the inspection, after reviewing the evidence provided by the home it was determined that for conditions #3 and #4 of Compliance Order #002 there was insufficient evidence to determine compliance.

The Director of Care (DOC) confirmed that the education for the registered staff did not include the recommendations for improvements from the assessments.

RN #117 confirmed that the assessments had not been reviewed with them during the huddle and one-on-one education sessions related to CO #002, and they did not attend a meeting that provided a review of the results of the audit and recommendations for improvements.

Signatures were obtained which included the date staff received the education but there was no education content posted in an area accessible to the nursing and dietary staff as per the order.

By failing to provide registered staff with the results of the audit and recommendations for improvement, or a posting of the education content for nursing and dietary staff, as per conditions #3 and #4 of compliance order #002, the licensee placed residents at risk of potential harm from inconsistencies with staff re-training.

Sources: home's CO #002 package materials, staff interviews.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
There was no history of non-compliance (NC) with FLTCA, 2021, s. 104 (4) issued for the Compliance Order #002 from Inspection Report #2024-1218-0001 dated March 8 , 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee failed to comply with condition #4 of Compliance Order (CO) #003 from inspection #2024-1218-0001, served on March 8, 2024, with a compliance due date of June 5, 2024.

Specifically,

4. Educate nursing and dietary staff who assist with serving meals on the appropriate time of when meals should be plated and served. Keep a documented record of this education, including date, content of education, who delivered the education, name of staff educated and make available to the Inspector immediately upon request.

Rationale and Summary:

At the time of the inspection, after reviewing the evidence provided by the home it was determined that for condition #4 of CO #003 there was insufficient evidence to determine compliance.

The home provided a list of the dietary staff who had received the education, as per CO #003.

The Nutritional Care Manager (NCM) confirmed that after cross referencing the current list of dietary staff, and the education sign off sheet, they could confirm that three staff had missed the education as required by condition #4 of CO #003.

By failing to provide all dietary staff with the education required in CO #003 condition #4, related to the appropriate time when meals should be plated and served, the licensee placed residents at risk of physical harm due to potentially incorrect meal provision from uninformed dietary staff.

Sources: CO #003 dietary staff education sign off sheet, NCM interview.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Written Notification NC #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246 / 22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
There was no history of non-compliance (NC) with FLTCA, 2021, s. 104 (4) issued for the Compliance Order #003 from Inspection Report #2024-1218-0001 dated March 8, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #001 DOORS IN A HOME

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 12 (1) 3.
Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

1. Remove all keys hanging in clear view at doorways to non-residential areas.

2. Devise and implement a method of securing all doors into non-residential areas to ensure that there is no access to those areas when unsupervised by staff.

3. Keep a record of the doors into non-residential areas throughout all areas of the home and the date that conditions one and two were met and provide to inspectors immediately upon request.

Grounds:

The licensee has failed to ensure that doors leading to non-residential areas were locked in a way to restrict unsupervised access to those areas by residents, and those doors be kept closed and locked when they are not being supervised by staff.

Rationale and Summary:

During the initial tour of the home, keys were observed to be hanging at doorways of multiple non-residential areas of the home, specifically soiled utility rooms. Materials kept inside the rooms included soiled linens and biohazardous waste from residents that were on hazardous drug precautions.

A personal support worker (PSW) used a key hanging from the doorway of a soiled utility room in a resident care area, to easily gain access to the room. Soiled linen and biohazardous waste was observed inside the soiled utility room.

The PSW confirmed that if a resident took the key that was hanging next to the soiled utility room door and went inside, there were items that were harmful inside, as staff discard soiled resident briefs (incontinence products) into a biohazard garbage inside the soiled utility room, from the residents who are on drug precautions.

The Administrator confirmed that the waste in the soiled utility room was biohazardous and required use of personal protective equipment (PPE) to handle, confirming that the lid to the biohazard bin was open and accessible inside the soiled utility room. They confirmed that some of the residents would be capable of using the key if they wanted to. They acknowledged that the hanging key made the soiled utility room accessible to residents and could be a potential hazard if they went in.

Hazardous drug precautions signage and personal protective equipment (PPE) stations were set up outside the resident's rooms who were on drug precautions. The signage informed individuals of the need to use PPE to prevent exposure to biohazardous human waste such as incontinence products.

By failing to lock soiled utility room doors in a way to restrict unsupervised access to a non-residential area, the licensee placed residents at potential risk of physical harm from exposure to biohazardous waste.

Sources: observations, hazardous drug precautions signage, staff interviews.

This order must be complied with by: September 13, 2024

COMPLIANCE ORDER CO #002 DINING AND SNACK SERVICE

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 79 (1) 4.
Dining and snack service

s. 79 (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. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

1. Develop a resident diet list for staff to reference that includes all resident diets, special needs, preferences, and any required adaptive aids, including a definition page for all diet types, acronyms, and short forms used in the list.

2. Develop and implement a protocol to ensure that staff have immediate access to an up-to-date diet list (as per condition 1) for reference during the provision of all meals and snacks. The protocol will include a method for ensuring that daily diet lists that are made available to staff are up to date with the registered dietician's orders.

3. Provide training regarding the requirement for referencing up-to-date diet lists prior to providing meals and snacks to residents, including a review of the protocol developed for condition #2 above. The training groups will include all staff who are responsible for the provision of meals and snacks to residents, including their supervisors and managers. Keep a record of the training that includes at a minimum, the training date and content, employee name, job title, and signature attesting to the completion of the training, and provide this record to inspectors immediately upon request.

4. A member of the management staff will perform one audit for each meal and snack service, once a week for three weeks, documenting if staff had easy

access to a current diet list and whether or not they referenced the list prior to serving residents their food and beverages. Keep a record of the audits including at a minimum, the name, position, and initials of the auditor, name and position of the staff that were audited, which meal or snack service was audited with date and time, corrective actions or education provided (if non-compliance was identified), date, job position and signature of any staff who required re-training. Provide audit record to inspectors immediately upon request.

Grounds:

The licensee failed to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs, and preferences,

On a specific day during the inspection both the north and south wing snack service carts had outdated diet lists from the prior month being used as a staff reference. On a different day Life Enrichment Aide (LEA) #105 was unable to find a resident diet list on the nutrition cart when they and other LEAs were observed to have started to serve residents their snacks.

LEA #103 confirmed that diet sheets on the snack carts were to be used for reference, but they often needed clarification as they didn't always understand what was written on them for example a regular diet with diabetic modifications and other short forms used by the registered dietician. They explained that they didn't have quick access to the care plans while in the dining room so would ask for clarification by speaking to the kitchen staff or asking other experienced co-workers.

LEA #106 explained that they didn't need the diet list because they were full time and knew the residents, so they could rely on memory to know what the resident's diets were.

The Registered Dietitian (RD) confirmed that the Nutritional Care Manager (NCM) was responsible for updating the diet lists / tick sheets and providing them to staff at point of service in the kitchen and the serving tables and on the snack / nutrition carts.

After discovering that the resident diet lists on the north and south wing snack service carts were dated for the prior month, the NCM confirmed that they were outdated and were not supposed to be there. They explained that the new process was to zip tie the updated diet lists to the carts so they wouldn't go missing and staff were to ensure that they were attached to the carts and referenced before serving any beverages or food to residents. They confirmed that the staff were expected to check the resident diet list every time, as it could change from day to day. They acknowledged that LEAs should have checked to ensure that a resident diet list was on the snack cart before they started to serve any residents.

The NCM explained that the worker that took the snack cart the day before with no diet list was made aware of the severity of this and would be ensuring in the future that they do not use a snack cart again without an attached diet list, re-educating them that they must reference the list as diets are always changing. The NCM also confirmed that the diet lists on the snack carts did not include information about resident special needs, preferences and adaptive aids.

The NCM initialed receiving eight resident diet updates on the RD Report (three in May and five in June) that occurred after the outdated diet list that was found for reference on the north and south snack carts.

The 'Meal Preparation and Service' policy directed that the diet lists shall be updated whenever there was a change made to a resident's care plan or nutrition profile, and the NCM will print and post lists regularly to ensure current information is displayed. It is the responsibility of all Nutritional Care Staff to regularly consult the Resident Diet List and to notify the NCM or Charge Nurse if an error is found.

By failing to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs and preferences, the licensee placed residents at risk of physical harm from potentially outdated / inaccurate diet information.

Sources: snack cart observation, resident diet lists, May and June 2024 RD Reports, staff interviews.

This order must be complied with by: September 13, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #003

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #003
Related to Compliance Order CO #002
Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246 / 22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
There was a compliance history from inspection #2024-1218-0001 for Dining and Snack Service - O. Reg. 246 / 22 s. 79 (1) 4., which resulted in a Compliance Order issued on March 8, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #003 INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

1. The IPAC Lead will provide training regarding the requirement for assisting residents to perform hand hygiene prior to serving meals and snacks to residents, including a review of the home's related hand hygiene policies. The training groups will include all staff who are responsible for the provision of meals and snacks to residents, including their supervisors and managers.

Keep a record of the training that includes at a minimum, the training date and content, employee name, job title, and signature attesting to the completion of the training, and a cross-referenced list of eligible employees that require the training to indicate that all have been trained. Provide this record to inspectors immediately upon request.

2. A member of the management team will perform one audit for each meal and snack service, once a week for three weeks, documenting if staff assisted residents with hand hygiene prior to serving their food and beverages. Keep an audit record which includes at a minimum, the name, position, and initials of the auditor, name and position of the staff that were audited, which meal or snack service was audited with date and time, if the staff member assisted the resident with hand hygiene (yes/no), any corrective actions or education provided (if non-compliance was identified), date, job position and signature of any staff who required re-training. Provide audit record to inspectors immediately upon request.

Grounds:

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented. Specifically, the licensee failed to assist residents to perform hand hygiene before snack service, in accordance with Additional Requirement 10.2 (c) under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022, last revised September 2023.

During an entertainment event, Life Enrichment Aide (LEA) #103 was observed to be serving beverages and cookies to two residents without offering hand hygiene assistance.

PSW #115 failed to offer hand hygiene assistance to a resident prior to providing them with a beverage during a morning snack service.

LEA #103 acknowledged that they had not provided assistance with hand hygiene before serving the two residents their drinks and cookies. They acknowledged that residents should have hand hygiene prior to snacks, and they were not sure if this was done when the residents came into the dining room at the start of the event or not, and they should have asked them.

PSW #115 confirmed that it was not part of their current practice to assist residents with hand hygiene before providing snacks, but this could easily be implemented because there was alcohol hand rub on the snack cart, and wall dispensers in the resident's bedrooms.

By failing to provide residents with hand hygiene assistance prior to snack service, the licensee put residents at risk of healthcare-associated infections from potential exposure to infectious organisms.

Sources: resident snack delivery observations, staff interviews.

This order must be complied with by: September 13, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and / or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and / or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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

438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.