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
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Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2020	2020_633577_0019 (A1)	015744-20, 016662-20, 017162-20	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

Amended by DEBBIE WARPULA (577) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Compliance due dates for s.3(1)9 and s.44 have changed to December 14, 2020, to allow the Licensee time required to achieve compliance.

Issued on this 26th day of October, 2020 (A1)

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

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

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Oct 26, 2020	2020_633577_0019 (A1)	015744-20, 016662-20, 017162-20	Critical Incident System

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300 Lillie Street THUNDER BAY ON P7C 4Y7

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

Amended by DEBBIE WARPULA (577) - (A1)

Amended 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): September 8 to 11 and 14 to 17, 2020

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:

-One log regarding improper transfer of a resident;

-One log regarding improper care of a resident; and

-One log regarding resident to resident abuse.

Complaint inspection #2020_633577_0020, was conducted concurrently with this CIS inspection

Findings of non-compliance related to s. 19(1), s. 36 and s. 6(7) will be found in the Complaint inspection #2020_633577_0020

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers (CMs), Registered Nurses (RNs), Resident Assessment Instrument Coordinators (RAI Coordinators), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Clinical Practice and Learning Registered Nurse, Learning and Telemedicine Facilitator, and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Personal Support Services
Responsive Behaviours
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
4 WN(s)
0 VPC(s)
4 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 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:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to have his or her participation in decision-making respected concerning cardiopulmonary resuscitation.

During Inspection #2020_768693_0012, a Voluntary Plan of Correction (VPC) was issued related to a resident who had not received proper medical intervention according to their wishes during a Code Blue. Staff interviews conducted during that inspection identified that staff hadn't had discussions with residents or families about not providing medical intervetion in an unwitnessed event and did not think that staff had been informing families or residents.

During an interview with an RN, they advised Inspector #577 that they hadn't had discussions with residents or family about no medical interventions in an unwitnessed event.

During an interview with the Administrator, Inspector #577 inquired of the home's actions taken to address the previous VPC issued, related to residents who wished to a particular status, and medical intervention in unwitnessed events. The Administrator advised that staff only had those conversations with newly admitted residents, not the residents who had existing Advance Directives for full resuscitation.

Sources: CIS report and interviews with the Administrator and other staff. [s. 3. (1) 9.]

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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 73. Staff qualifications
Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,
(a) have the proper skills and qualifications to perform their duties; and
(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..

Findings/Faits saillants :

1. The licensee has failed to ensure that all the staff of the home, including the persons mentioned in sections 70 to 72, had the proper skills and qualifications to perform their duties related to a particular recertification.

During an interview with an RPN they advised Inspector #577 that they were not up to date with their certification and didn't recall when they last had their re-certification.

A record review of a current Registered Practical Nurse (RPN) job posting for the long-term care home had indicated "Current Basic Cardiac Life Support" (BCLS) certification as a prerequisite to employment.

During an interview with the Clinical Practice and Learning Registered Nurse #104 they advised Inspector #577 that Personal Support Workers (PSWs) and registered staff were required to have the particular certification and renewal every two years.

Sources: CIS report, progress notes, investigation notes, SJCG Hogarth RPN job posting, employee file and training records, and interviews with an RPN and other staff. [s. 73. (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of a resident.

A review of the home's policy Suctioning of the Airway indicated that each home area was to have at least one suction catheter, a collecting bottle, tubing and a suction machine easily accessible and in optimum working condition and available at all times for emergency use.

During an interview with an RN they advised Inspector #577 that during a medical intervention of a resident, they had requested an RPN obtain specific equipment. The RPN couldn't get the equipment to work.

During an interview with the RPN they advised Inspector #577 that the specific equipment wasn't brought to the resident's room during the medical intervention, stating, "We don't do that here"; they further advised that they told the RN that they don't provide a particular intervention and had never witnessed anyone provide that intervention.

During an interview with a CM, they advised that each unit has a specific sheet for the specific equipment, to be checked every night by the RPN. Inspector #577 and the CM together reviewed the specific sheet for that particular unit for a specified month. The sheet indicated that it was checked on three night shifts. The CM advised that it should have been checked every night.

During an interview with the Administrator, they advised Inspector #577 that each unit was required to have a sealed emergency kit on the unit. Inspector #577 advised the Administrator that three units had been checked by the Inspector and none had an emergency kit that was sealed. The Administrator and Inspector #577 together, toured a nursing unit and found the emergency kit to be without a seal. The Administrator advised that staff were required to have checked the emergency kits after use to ensure proper supplies and were to have re-sealed the kit.

Sources: CIS report, progress notes, investigation notes, the home's Suctioning of the Airway policy, the home's Code Blue in Long-Term Care policy, Pre-Start Checklist, employee files and training records, and interviews with an RPN and

other staff. [s. 44.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(a) has at least one year of experience working as a registered nurse in the long-term care sector; O. Reg. 79/10, s. 213 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section, had at least one year of experience working as a registered nurse (RN) in the long-term care sector.

Inspector #577 reviewed the DOC's employee file with a focus on qualifications for the DOC position. The file did not identify that the DOC had any experience working as an RN in the long-term care sector.

During an interview with Inspector #577, the recently hired Director of Care (DOC) confirmed that they had not worked in the long-term care sector prior to beginning their current role in the home.

During an interview with Inspector #577 the Administrator stated that the home's recently hired Director of Nursing and Personal Care (DOC) did not meet all of the requirements outlined in the legislation, and specifically stated that they did not have one year of experience working as an RN in the long-term care sector.

Sources: an employee file, interviews with the Administrator and other staff. [s. 213. (4) (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 26th day of October, 2020 (A1)

[redacted]

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DEBBIE WARPULA (577) - (A1)
Inspection No. / No de l'inspection :	2020_633577_0019 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	015744-20, 016662-20, 017162-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 26, 2020(A1)
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:

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must comply with s. 3 (1) 9 of the LTCHA:

Specifically, the licensee must:
-identify all the residents in the home with Advance Directives that indicate cardiopulmonary resuscitation (CPR) as their wishes for resuscitation; and
-ensure those residents have been informed of the home's Code Blue policy.

Grounds / Motifs :

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

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to have his or her participation in decision-making respected concerning cardiopulmonary resuscitation.

During Inspection #2020_768693_0012, a Voluntary Plan of Correction (VPC) was issued related to a resident who had not received proper medical intervention according to their wishes during a Code Blue. Staff interviews conducted during that inspection identified that staff hadn't had discussions with residents or families about not providing medical intervetion in an unwitnessed event and did not think that staff had been informing families or residents.

During an interview with an RN, they advised Inspector #577 that they hadn't had discussions with residents or family about no medical interventions in an unwitnessed event.

During an interview with the Administrator, Inspector #577 inquired of the home's actions taken to address the previous VPC issued, related to residents who wished to a particular status, and medical intervention in unwitnessed events. The Administrator advised that staff only had those conversations with newly admitted residents, not the residents who had existing Advance Directives for full resuscitation.

Sources: CIS report and interviews with the Administrator and other staff. [s. 3. (1) 9.]

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

Severity: There was minimal harm as there haven't been any unwitnessed events since last inspection.

Scope: The scope of this non-compliance was a pattern because there was inaction after the previous voluntary plan of correction (VPC), and residents' with directives for cardiopulmonary resuscitation (CPR) haven't been identified and informed.

Compliance history: One voluntary plan of correction (VPC) was issued to the home related to s. 3 (1) 9 in the past 36 months.
(577)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 14, 2020(A1)

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 73. Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,
(a) have the proper skills and qualifications to perform their duties; and
(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..

Order / Ordre :

The licensee must comply with s. 73 (a) of the LTCHA.

Specifically, the licensee must:
-ensure an RPN and all registered staff have the proper skills and certification to perform Basic Cardiac Life Support (BCLS)

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

Grounds / Motifs :

1. The licensee has failed to ensure that all the staff of the home, including the persons mentioned in sections 70 to 72, had the proper skills and qualifications to perform their duties related to a particular recertification.

During an interview with an RPN they advised Inspector #577 that they were not up to date with their certification and didn’t recall when they last had their re-certification.

A record review of a current Registered Practical Nurse (RPN) job posting for the long-term care home had indicated “Current Basic Cardiac Life Support" (BCLS) certification as a prerequisite to employment.

During an interview with the Clinical Practice and Learning Registered Nurse #104 they advised Inspector #577 that Personal Support Workers (PSWs) and registered staff were required to have the particular certification and renewal every two years.

Sources: CIS report, progress notes, investigation notes, SJCG Hogarth RPN job posting, employee file and training records, and interviews with an RPN and other staff. [s. 73. (a)]

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

Severity: There was actual risk of harm to a resident as there were grounds to support a lack of knowledge and skill in how to respond to a resident's need for BCLS.

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

Compliance history: The licensee was found to be non-compliant with different sections of the legislation in the last 36 months.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 24, 2020

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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Order / Ordre :

The licensee must comply with s. 44 of O. Reg. 79/10.

Specifically, the licensee must:
-ensure that each nursing unit has an emergency kit, with proper supplies and a seal;
-ensure that night staff are checking the suction machine and documenting on the "Pre-Start Checklist";
-perform weekly audits of the suction machine "Pre-Start Checklist" to ensure they are working and being checked; and
-document the audits until 30 consecutive days of adherence is achieved.

Grounds / Motifs :

1. The licensee has failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of a resident.

A review of the home's policy Suctioning of the Airway indicated that each home area was to have at least one suction catheter, a collecting bottle, tubing and a suction machine easily accessible and in optimum working condition and available at all times for emergency use.

During an interview with an RN they advised Inspector #577 that during a medical intervention of a resident, they had requested an RPN obtain specific equipment. The RPN couldn't get the equipment to work.

During an interview with the RPN they advised Inspector #577 that the specific equipment wasn't brought to the resident's room during the medical intervention, stating, "We don't do that here"; they further advised that they told the RN that they don't provide a particular intervention and had never witnessed anyone provide that intervention.

During an interview with a CM, they advised that each unit has a specific sheet for the specific equipment, to be checked every night by the RPN. Inspector #577 and the CM together reviewed the specific sheet for that particular unit for a specified month. The sheet indicated that it was checked on three night shifts. The CM advised that it should have been checked every night.

During an interview with the Administrator, they advised Inspector #577 that each unit was required to have a sealed emergency kit on the unit. Inspector #577 advised the Administrator that three units had been checked by the Inspector and none had an emergency kit that was sealed. The Administrator and Inspector #577 together, toured a nursing unit and found the emergency kit to be without a seal. The Administrator advised that staff were required to have checked the emergency kits after use to ensure proper supplies and were to have re-sealed the kit.

Sources: CIS report, progress notes, investigation notes, the home's Suctioning of the Airway policy, the home's Code Blue in Long-Term Care policy, Pre-Start Checklist, employee files and training records, and interviews with an RPN and other staff. [s. 44.]

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

Severity: There was actual risk of harm to a resident as the suction equipment was checked for three out of 31 days during a particular month. Staff could not suction a resident during resuscitation as it was unusable.

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

Compliance history: The licensee was found to be non-compliant with different sections of the legislation in the past 36 months.

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

(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 14, 2020(A1)

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

Order # / No d'ordre: 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(a) has at least one year of experience working as a registered nurse in the long-term care sector;
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and
(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).

Order / Ordre :

The licensee must comply with s. 213 (4) a of O. Reg. 79/10.

Specifically, the licensee must prepare, submit and implement a plan to ensure that the home has a qualified Director of Nursing and Personal Care. The plan must include but is not limited to:
-what steps the home will undertake to ensure that anyone holding the title of Director of Nursing and Personal Care is qualified; and
-a written description of the role and the organization structure describing who the Director of Nursing and Personal Care is subordinate to, and who reports to the Director of Nursing and Personal Care.

Please submit the written plan for achieving compliance for inspection 2020_633577_0019 to Debbie Warpula, LTC Homes Inspector, MLTC, by email to sudburySAO.moh@ontario.ca by October 15, 2020.

Please ensure that the submitted written plan does not contain any PI/PHI.

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

Grounds / Motifs :

1. The licensee has failed to ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section, had at least one year of experience working as a registered nurse (RN) in the long-term care sector.

Inspector #577 reviewed the DOC's employee file with a focus on qualifications for the DOC position. The file did not identify that the DOC had any experience working as an RN in the long-term care sector.

During an interview with Inspector #577, the recently hired Director of Care (DOC) confirmed that they had not worked in the long-term care sector prior to beginning their current role in the home.

During an interview with Inspector #577 the Administrator stated that the home's recently hired Director of Nursing and Personal Care (DOC) did not meet all of the requirements outlined in the legislation, and specifically stated that they did not have one year of experience working as an RN in the long-term care sector.

Sources: an employee file, interviews with the Administrator and other staff. [s. 213. (4) (a)]

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

Severity: There was minimal risk of harm to the residents.

Scope: The scope of this non-compliance was widespread as it affects all residents, as the Director of Care doesn't have experience working as an RN in the long-term sector.

Compliance history: The licensee was found to be non-compliant with different sections of the legislation in the last 36 months.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2020

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

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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:

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

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

Order(s) of the Inspector

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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 26th day of October, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by DEBBIE WARPULA (577) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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