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

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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
Oct 1, 2020	2020_633577_0020	014476-20, 014742-20, 014743-20, 015893-20, 016673-20, 017054-20, 017720-20, 017903-20	Complaint

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

DEBBIE WARPULA (577), DAVID SCHAEFER (757), JULIE KUORIKOSKI (621), MELISSA HAMILTON (693)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 8 to 11 and 14 to 17, 2020

The following intakes were inspected upon during this Complaint (CO) inspection:
-Four logs regarding alleged improper care of a resident;
-Two logs regarding resident care concerns related to an incorrect diet and choking ;
-One log regarding resident care concerns related to resident falls and responsive behaviours; and
-One log regarding resident care concerns related to medication.

Critical Incident System (CIS) inspection #2020_633577_0019, was conducted concurrently with this Complaint inspection

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), Consultant Pharmacist, Registered Dietitian (RD), Dental Hygienist, Nutrition Manager, Dietary Aide (DA), Behavioural Science of Ontario Personal Support Worker (BSO), 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:

Dining Observation
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **11 WN(s)**
- **5 VPC(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dental care set out in the plan of care for a resident was based on an assessment by the Dental Hygienist and the needs and preferences of the resident.

The home received a complaint related to oral care of a resident, which indicated that the resident's substitute-decision maker (SDM) had requested a specific daily intervention to be included in the resident's care plan.The Dental Hygienist stated that they had recommended this during a conversation including the Clinical Manager, and the resident's SDM. The investigation notes related to the complaint indicated that this was also the resident's preference. The resident's care plan did not include the specific intervention, instead indicating only that "oral care" should be provided. A PSW indicated that they did not use a specific device when providing oral care to the resident, and instead used a different device.

Sources: A resident care plan; the home's internal complaint investigation file; and

interviews with the DH, a PSW, and a CM. [s. 6. (2)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other.

A review of the progress notes for a resident, identified that their family member had made a request to an RPN to speak with a physician regarding care concerns for the resident. Additionally, the progress notes identified that the RPN had indicated that the resident's family wanted to speak to the doctor and they had left a note in the physician's book.

A review of the physician's book, identified that there were no notes in the book indicating that the family of the resident wanted to speak with the physician.

During an interview with the RPN, they indicated that they had called the physician numerous times and stated that the resident's family wanted to speak with them. The RPN indicated that if they had called the physician, they would have documented it in the resident's progress notes.

During an interview with a CM, they indicated that the RPN stated that they called the physician, but they had not communicated this with the resident's family, and that if they had called the physician, they should have documented the calls.

Sources: progress notes; physician's book; interviews with an RPN, a CM, and other staff; complaint submitted to the Director; and the LTCH's investigation file. [s. 6. (4) (a)]

3. The licensee has failed to ensure that a resident's eating and nutrition care, set out in the plan of care was provided, as specified in the plan.

A complaint and associative CIS report for the same incident, identified that a resident required a medical intervention after a PSW provided a snack. The CIS report identified that the resident required a specific textured diet and specified assistance while eating.

A letter from a Clinical Manager to a PSW identified that they gave a resident a snack that was not the correct texture, resulting in a potential risk to the resident, and the care plan, as a consequence, was not followed.

During an interview with the CM, they reported that they completed the CIS report for this

incident, and confirmed that a resident was given an incorrect diet texture for their specified snack, by a PSW, and was also not supervised during snack time, as per their plan of care.

Sources: a resident's care plan; letter to a PSW; and an interview with a Clinical Manager. [s. 6. (7)]

4. a) The licensee has failed to ensure that the care set out in a resident's care plan related to dining, was provided to the resident as specified in their plan.

A resident's current care plan stated that the resident was at a particular risk and required specific assistance for eating, and that staff were to have implemented specific interventions. Inspector #757 observed two PSWs on two different days and observed that the specific interventions weren't being implemented.

Sources: a resident's current care plan; observations of the provision of dining assistance; and interviews with two PSWs, as well as other relevant staff members.

b) The licensee has failed to ensure that the care set out in a resident's care plan related to oral care, was provided to the resident as specified in their plan.

A resident's current care plan stated that staff were to provide specific assistance for oral care. The home's "Oral Health Assessment and Care" policy defined oral care as including "cleaning and flossing of teeth, as well as "cleaning of the gums and tongue". On observation of the resident's room and bathroom, a specific apparatus could be located. Two PSWs stated that they did not provide this intervention during oral care for the resident. The resident stated that they had never received the specified intervention as part of their oral care in the home. The Dental Hygienist (DH) indicated that the resident required specific assistance for dental care, that the resident had substantial characteristics, and that the lack of providing the specified intervention would have contributed.

Sources: The resident's current care plan; observations of the resident's room; Oral Health Assessment and Care Policy; and interviews with the resident, the DH, PSWs, and other relevant staff members. [s. 6. (7)]

5. The licensee has failed to ensure that the care set out in a resident's plan of care related to Advance Directives, was provided to the resident as specified in the plan.

A record review of the resident's care plan and Advance Directives indicated that the resident wished a specific medical intervention.

A review of the investigation notes and interviews indicated that an RPN wasn't aware of the resident's care plan or advance directives; the RPN advised that the resident suffered a specific medical condition on arrival to their room and they left the resident to go call the RN, causing a delay in treatment; a medical intervention wasn't performed and a specific intervention ceased after a specified amount of time.

During an interview with the Administrator, they advised that staff followed resident's care plan as they attempted a medical intervention, a specified intervention should have been provided, there was a delay in providing treatment as the RPN was unaware of their specific status and left the resident in their room to call the RN.

Sources: a critical incident report, progress notes, investigation notes, care plan, Advance Directives, the home's Plan of Care policy, employee file and training records, and interviews with an RPN and other staff. [s. 6. (7)]

6. The licensee has failed to ensure that PSW staff who provided direct care to a resident, were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

A complaint and associative CIS report, identified that a resident required a medical intervention after a PSW provided the resident with a snack. The CIS report identified that the resident required a specific textured diet.

During a review of the resident's progress notes, it was identified that Speech Language Pathology (SLP) services assessed the resident, and determined that they required a diet texture to a specific texture.

A review of the resident's care plan, identified the resident was now on a specific texture diet.

A subsequent review of the resident's Kardex identified the resident on different texture diet.

During interviews with two PSWs, they reported that if they needed information about a

resident's diet needs, they would review their Kardex. Both PSWs reported that they did not have direct access to diet information from the resident's EMR. They reported that the resident was on a specific diet texture at the time of inspection, but on review of the resident's Kardex, they discovered that the resident's Kardex had not been updated to reflect their current diet texture requirements.

During an interview with an RPN, they reported that registered staff were responsible for making changes to resident care plans (including Kardexes), and that following any change, a copy of the updated Kardex was to be printed and replace the existing Kardex information in the PSWs black care binder. The RPN reviewed the resident's most current diet order and Kardex information found in PSWs assignment binder, and found the Kardex to be out of date. The RPN stated that as a result of the Kardex being outdated, that PSWs did not have immediate and readily available access to diet care plan information since its update, for the resident, and should have.

Sources: a complaint intake; a CIS report; a resident's progress notes; a resident's Kardex; and interviews with PSWs, and an RPN. [s. 6. (8)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident; to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was notified when the resident's personal assistive device was not in good working order or required repair.

The home received a complaint related to the condition of a resident's personal assistive device, which alleged that the device was not in good working order and was not able to maintain a specified position. The resident's care plan stated that their assistive device was to be at a specified position during all meals. The home's investigation file related to the complaint indicated that the assistive device required repair and had not been able to maintain a specified position for at least two weeks. A CM stated that staff should have seen that the assistive device was not at the specified position, and should have contacted the resident's SDM to inform them it required repair.

Sources: A resident's care plan; the home's internal complaint investigation file; and an interview with a CM. [s. 38. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident or the resident's substitute decision-maker is notified when the resident's personal aids or equipment are not in good working order or require repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours.

A review of the home's investigation file, which included progress notes, indicated that a resident exhibited specific behaviours on the two days following admission. The notes indicated that the resident was wandering their home unit and was found in another resident's room with injuries.

A review of the resident's plan of care identified that there were no strategies developed for staff to respond to the resident's behaviours.

During an interview with an RPN, they indicated that the resident was exhibiting specific behaviours, and they were not able to manage their behaviours, as they "did not have any idea on what to do", because the resident was new to the home. The RPN indicated that there were no interventions in place, within the resident's plan of care for their behaviours.

Sources: progress notes; care plan; interviews with an RPN and other staff; physician's book; Mental Health and Responsive Behaviours policy; complaint submitted to the Director; and the LTCH's investigation file. [s. 53. (4) (b)]

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 for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining service for a resident included proper techniques to assist with eating, including safe positioning of the resident.

A resident's care plan indicated that they were at a particular risk, and required their assistive device to be in a specific position during all meals. The care plan specified that if staff were unable to position the assistive device in a specific position, the resident was to go back to bed and be fed there in a specific position. A CIS report indicated that the resident had a specified incident and the resident's assistive device was in a different position.

Sources: the resident's care plan, a CIS report; the home's internal complaint investigation file; and interviews with a CM and other relevant staff members. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

A resident was prescribed a medication that was to be taken at a specified time before a certain activity. The resident was administered the medication by an RPN and again later by another RPN.

During an interview, a Clinical Manager indicated that an RPN made a medication error when they administered a second dose of the medication to the resident, and that the resident experienced a change in condition.

Sources: Complaint submitted to the Director; the resident's electronic medication administration record (EMAR); prescriber's orders for the resident; the LTCH's safety report; Administration of Medications-General Guidelines Policy and other policies, and interviews with a Clinical Manager and other staff. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from neglect by an RPN and an RN.

CO #001 was issued during inspection # 2020_768693_0011 pursuant to the LTCHA, s. 19 with a compliance due date of October 5, 2020. As the compliance order was not due to be complied, these findings will be issued as a WN to further support the order.

Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A review of the home's policy Zero Tolerance of Resident Abuse and Neglect Program indicated that the home was committed to having provided a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. They had zero tolerance for abuse and neglect and any form of abuse or neglect by any person, whether through deliberate acts or negligence, would not be tolerated.

A review of the home's policy Code Blue in Long-Term Care indicated that the first responder was to announce Code Blue with the location over their telephone intercom system; they were to don appropriate Personal Protective Equipment (PPE), which included gown, gloves, N95 mask and eye protection; they were to stay with the resident until help arrived; the first registered staff were to have arrived with the emergency bag/kit; a staff member was to confirm the wishes of the resident regarding resuscitation; a rapid assessment of the resident to confirm an arrested state; if the resident was a full code and the arrest was witnessed, they were to ensure that 911 had been called and proceed with basic life support until the resident responded or transfer of care to the paramedics.

A review of the home's policy Plan of Care indicated that the plan of care identified care needs to allow the care team to implement strategies to provide appropriate care; it served as a communication tool which promoted the safe and effective resident care and provided documentation which identified immediate risks to safety and care needs to allow the care team to implement strategies to mitigate risk and provide appropriate care; the plan of care would be reflective of the resident's goals and preferences.

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

A record review of the resident's care plan and Advance Directives indicated that the resident wished a specific medical intervention.

A review of the home's investigation file included the following documentation:

-the resident suffered a medical incident and an RPN transported them to their room in their wheelchair;
-interview notes with the RPN and a CM indicated that the resident suffered a medical incident during transport to their room; they weren't aware that the resident was a particular status; only a specified intervention was provided to the resident; the CM instructed the RPN that the medical intervention should have begun in the dining room; and
-interview notes with the RN, the CM and the Administrator indicated that the RPN informed them that the resident suffered a medical incident on arrival to their room; they

had asked the RPN to get specific equipment and call a code; they provided a specified intervention for a specified time and made the decision to cease the intervention.

During an interview with an RN, they advised Inspector #577 that the RPN should not have left a resident sitting in their room after suffering a medical incident, to go make a phone call to the RN; they reported that a specific Code and 911 should have been called; further, specific equipment should have been readily available and working; specified interventions should have continued until the paramedics arrived.

During an interview with the CM, they advised Inspector #577 that the RN asked the RPN to get specific equipment and the RPN couldn't get the equipment connected, and the RN announced that they were stopping the Code. They further confirmed that a Code wasn't announced, staff were not wearing PPE, staff were not providing a specific medical intervention, and they didn't call 911; they advised that staff should have initiated a specific medical intervention and there was a delay in initiating a specific intervention as the RPN wasn’t aware of the resident’s medical status. They confirmed that staff had not followed the Code policy and the resident was neglected as the staff failed to have provided the resident with the care and assistance required and included a pattern of inaction that jeopardized their health.

Sources: a CIS report, progress notes, investigation notes, the home’s Zero Tolerance of Resident Abuse and Neglect Program, the home’s Code Blue in Long-Term Care policy, the home's Plan of Care policy, the home’s Suctioning of the Airway policy, care plan, advance directives, employee files and training records, and interviews with a CM and other staff. [s. 19. (1)]

2. The licensee has failed to ensure that a resident was protected from neglect by the licensee or staff.

A review of the home’s investigation file, which included progress notes, indicated that a resident exhibited responsive behaviours for a specified amount of time following admission. The notes indicated that the resident was wandering their home unit and was found in another resident’s room with injuries. Additionally, the notes indicated that the resident sustained a fall and suffered a significant injury.

See WN #1, finding #2; WN #2, finding #1; WN #9, finding #2 and WN #10, finding #2 for further details.

During an interview with the CM, they indicated that if there were behavioural interventions in place for the resident, the resident's safety and well-being would have been maintained; that the resident sustained a significant injury; their behaviours weren't managed; and that the resident needed more interventions in place to ensure their safety and well-being was not jeopardized.

Sources: progress notes; care plan; medical record; interviews with a CM and other staff; physician's book; Mental Health and Responsive Behaviours policy; Zero Tolerance of Resident Abuse and Neglect Program; Fall Prevention and Management Program; complaint submitted to the Director; and the LTCH's investigation file. [s. 19. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written policy in place to promote zero tolerance of abuse and neglect of a resident was complied with.

CO #001 was issued during inspection # 2020_768693_0013 pursuant to the LTCHA, s. 20 (1) with a compliance due date of October 5, 2020. As the compliance order was not due to be complied, these findings will be issued as a WN to further support the order.

A CIS report submitted to the Director identified that a resident required a medical intervention after a PSW provided a snack inconsistent with the resident's specific textured diet.

A review of the home's CIS investigation notes included documentation from a CM to an RN, which identified they had received an email from another CM about the incident two days later, and that it was considered a late report to the Director. Additionally, a note from a CM to another CM, identified that the email communication from an RN concerning the incident involving the resident, resulted in late reporting, as on further review of the incident, it was determined to be reportable for incompetent care.

A review of the home's Extendicare policy Zero Tolerance of Resident Abuse and Neglect: Report and Reporting identified that any person who had reasonable grounds to suspect improper or incompetent care of a resident, which resulted in harm or risk of harm to a resident, immediately reported the suspicion and information upon which it was based, to the Director of the Ministry of Health and Long-Term Care ("the Ministry"). Further, the policy identified that the nurse was responsible to call the manager on-call immediately upon suspecting or becoming aware of abuse or neglect of a resident.

During an interview with a CM, they confirmed that the RN did not follow the home's reporting policy, which required a call be made to the Manager on-call (if incident occurred after hours), to discuss the incident and whether it would be a reportable incident. The CM reported that instead, the RN emailed a CM, who was not on-call at the time, which resulted in a late report of the incident to the Director, a specified amount of time later.

Sources: a CIS report; home's CIS investigation notes; Extendicare policy Zero Tolerance of Resident Abuse and Neglect: Response and Reporting; and interviews with a CM and other staff. [s. 20. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

CO #001 was issued during inspection # 2020_768693_0012 pursuant to the LTCHA, s. 24 (1) with a compliance due date of October 5, 2020. As the compliance order was not not due to be complied, these findings will be issued as a WN to further support the order.

A resident was prescribed a medication that was to be taken at a specific time before a specified activity. The resident was administered the medication by an RPN and again later by another RPN.

During an interview, the Administrator indicated that the allegation from the resident's family member was an allegation of incompetent care.

Sources: Complaint submitted to the Director; the LTCH's investigation file and notes; Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy; and an interview with the Administrator. [s. 24. (1)]

WN #9: 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 has failed to ensure that two staff members used safe techniques when transferring a resident in a specific device.

CO #002 was issued during inspection # 2020_768693_0013 pursuant to O. Reg. 79/10, s. 36 with a compliance due date of October 19, 2020. As the compliance order was not due to be complied, these findings will be issued as a WN to further support the order.

The home's Safe Lifting with Care Program and Mechanical Lift policy required two staff

at all times and and they were to have remained with the resident during the entire time an apparatus was connected to a specific device.

The home's investigation notes indicated that two PSWs were in the process of transferring a resident in a specific device; a PSW was giving another PSW directions and they became upset and left the room saying they were getting help; the resident was left elevated in the apparatus and the PSW was left alone with the resident.

During an interview with a CM, they advised that two staff were required to be present at all times during a transfer, and when the resident was connected to the apparatus, the PSW should not have left the room.

Sources: a CIS report, progress notes, investigation notes, the home's Mechanical Lifts Policy, the home's Safe Lifting with Care Program, employee files and training records, and interviews with a PSW and other staff. [s. 36.]

2. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident off the floor.

A review of the progress notes for the resident identified that they sustained a fall and experienced pain in their hip.

A review of the home's investigation file, identified that an RPN helped the resident up, without utilizing a mechanical lift; even though the resident had experienced new onset pain.

During an interview with a CM, they indicated that after the resident's fall, staff should have used a mechanical lift to lift the resident, but that they did not; and an improper transfer of the resident was completed.

Sources: Interviews with a CM and other staff, progress notes, Fall Prevention and Management Program; complaint submitted to the Director; and the LTCH's investigation file. [s. 36.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury for a resident was developed and implemented in the home, related to documentation on a specific monitoring record and pain assessments.

CO #003 was issued during inspection # 2020_768693_0013 pursuant to O. Reg. 79/10, s. 48. (1) 1 with a compliance due date of October 19 , 2020. As the compliance order was not due to be complied, these findings will be issued as a WN to further support the order.

A review of progress notes for the resident identified that the resident sustained an unwitnessed fall with an injury.

A review of the resident’s medical record identified a specific monitoring record that was initiated after the resident’s fall indicated that staff were to complete pain assessments after an unwitnessed fall every hour for four hours, and every eight hours for 72 hours.

Together with the Inspector, the CM reviewed the specific monitoring record and indicated that no pain assessments were documented on the record, after the resident’s fall.

Sources: Interviews with a CM and other staff; resident’s progress notes and medical

record; Fall Prevention and Management Program; and a post falls assessment. [s. 48. (1) 1.]

2. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury for a resident was developed and implemented in the home, related to documentation on a specific monitoring record.

A review of the progress notes for a resident, identified that they sustained falls on a particular day.

A further review of the resident's medical record, and progress notes, indicated that the first fall that occurred was an unwitnessed event, in which the resident was found with an injury. The Inspector was unable to identify documentation that indicated a specific monitoring record to have been completed for this fall.

During an interview with an RPN, they indicated that when a resident sustained an unwitnessed fall, staff were required to complete a specific monitoring record; and that for all falls, a post-fall huddle was to be held. The RPN indicated that they did not complete either for the resident's fall because they did not know that the resident fell, they had only suspected that they did.

Sources: Interviews with an RPN and other staff; resident's progress notes and medical record; Fall Prevention and Management Program; complaint submitted to the Director; and the LTCH's investigation file. [s. 48. (1) 1.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of the progress notes for a resident, identified that they sustained falls on a particular day.

A further review of the resident's medical record, and progress notes, indicated that the first fall that occurred was an unwitnessed event, in which the resident was found with an injury. The Inspector reviewed the assessments, and did not identify a completed post falls assessment for the resident's initial fall.

During an interview with a CM, they indicated that staff were required to complete a post falls assessment after a resident had fallen.

Sources: Interviews with a CM and other staff; progress notes and medical record; e-assessments; Fall Prevention and Management Program; complaint submitted to the Director; and the LTCH's investigation file. [s. 49. (2)]

Issued on this 26th day of October, 2020

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) :	DEBBIE WARPULA (577), DAVID SCHAEFER (757), JULIE KUORIKOSKI (621), MELISSA HAMILTON (693)
Inspection No. / No de l'inspection :	2020_633577_0020
Log No. / No de registre :	014476-20, 014742-20, 014743-20, 015893-20, 016673-20, 017054-20, 017720-20, 017903-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 1, 2020
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

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. 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).

Order / Ordre :

The licensee must comply with s. 6(7) of the LTCHA.

Specifically, the licensee must:
-ensure that a resident's care plan interventions related to diet texture is provided;
-ensure that a resident's care plan interventions related to feeding and oral care is provided;
-identify the residents in the home whose Advance Directives indicate "Full Code" and ensure that staff are aware of residents' Advance Directives and comply with the residents' wishes;
-perform weekly audits of two residents' plans of care to ensure staff are providing care as specified in the residents' plans of care; and
-document the audits and continue auditing until 30 consecutive days of adherence is achieved.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident's eating and nutrition care, set out in the plan of care was provided, as specified in the plan.

A complaint and associative CIS report for the same incident, identified that a resident required a medical intervention after a PSW provided a snack. The CIS report identified that the resident required a specific textured diet and specified assistance while eating.

A letter from a Clinical Manager to a PSW identified that they gave a resident a snack that was not the correct texture, resulting in a potential risk to the resident, and the care plan, as a consequence, was not followed.

During an interview with the CM, they reported that they completed the CIS report for this incident, and confirmed that a resident was given an incorrect diet texture for their specified snack, by a PSW, and was also not supervised during snack time, as per their plan of care.

Sources: a resident's care plan; letter to a PSW; and an interview with a Clinical Manager. [s. 6. (7)]
(621)

2. a) The licensee has failed to ensure that the care set out in a resident's care plan related to dining, was provided to the resident as specified in their plan.

A resident's current care plan stated that the resident was at a particular risk and required specific assistance for eating, and that staff were to have implemented specific interventions. Inspector #757 observed two PSWs on two different days and observed that the specific interventions weren't being implemented.

Sources: a resident's current care plan; observations of the provision of dining assistance; and interviews with two PSWs, as well as other relevant staff members.

b) The licensee has failed to ensure that the care set out in a resident's care plan related to oral care, was provided to the resident as specified in their plan.

A resident's current care plan stated that staff were to provide specific assistance for oral care. The home's "Oral Health Assessment and Care" policy defined oral care as including "cleaning and flossing of teeth, as well as "cleaning of the gums and tongue". On observation of the resident's room and bathroom, a specific apparatus could be located. Two PSWs stated that they did not provide this intervention during oral care for the resident. The resident stated that they had never received the specified intervention as part of their oral care in the home. The Dental Hygienist (DH) indicated that the resident required specific assistance for dental care, that the resident had substantial characteristics, and that the lack of providing the specified intervention would have contributed.

Sources: The resident's current care plan; observations of the resident's room; Oral Health Assessment and Care Policy; and interviews with the resident, the DH, PSWs, and other relevant staff members. [s. 6. (7)] (757)

3. The licensee has failed to ensure that the care set out in a resident's plan of care related to Advance Directives, was provided to the resident as specified in the plan.

A record review of the resident's care plan and Advance Directives indicated that the resident wished a specific medical intervention.

A review of the investigation notes and interviews indicated that an RPN wasn't aware of the resident's care plan or advance directives; the RPN advised that the resident suffered a specific medical condition on arrival to their room and they left the resident to go call the RN, causing a delay in treatment; a medical intervention wasn't performed and a specific intervention ceased after a specified amount of time.

During an interview with the Administrator, they advised that staff followed resident's care plan as they attempted a medical intervention, a specified intervention should have been provided, there was a delay in providing treatment as the RPN was unaware of their specific status and left the resident in their room to call the RN.

Sources: a critical incident report, progress notes, investigation notes, care plan, Advance Directives, the home's Plan of Care policy, employee file and training records, and interviews with an RPN and other staff. [s. 6. (7)]

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

Severity: There was actual risk of harm to three residents; there were grounds to support a lack of knowledge of a resident's care plan and Advance Directives; a resident was given food unsupervised, of incorrect texture and required a medical intervention, and a resident was not provided with the proper feeding interventions and oral care.

Scope: The scope of this non-compliance was isolated as it affected three

residents.

Compliance history: In the last 36 months, the licensee was found to be non-compliant with LTCHA
s. 6 (7). Two Compliance Orders (COs), six Voluntary Plans of Correction (VPCs), and three Written Notifications (WN) were issued.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 29, 2020

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 1st day of October, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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