Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 9, 2019	2019_740621_0029	018019-19, 018251-19	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

JULIE KUORIKOSKI (621)

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 23 - 27, 2019.

The following intakes were inspected during this Complaint Inspection:
- One intake related to staff to resident abuse and neglect, medication management, food production and dining services; and
- One intake regarding alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Regional Director for Extendicare Assist, the Administrator, a Clinical Manager, the Resident Engagement Coordinator, the Interim Food Services Manager (Interim FSM), the Food Production Supervisor, a Psychogeriatric Resource Consultant (PRC), Registered Dietitians (RDs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides and a Housekeeping Aide.

The Inspector also reviewed the home's supporting documentation, including investigation records, relevant resident health care records, food production documents, and specific licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development of the resident's plan of care.

A complaint was received by the Director on a day in September 2019, which identified concerns that the home had changed a specific number of medication orders without consent, and had subsequently found resident #001 in a particular condition.

During a review of resident #001's healthcare record, the Inspector identified a specific number of medication orders processed two separate days in August 2019. On review of both order records, a certain area of the order record was left blank.

During an interview with RPN's #102 and #116, they reported that RPN staff were responsible for reviewing and processing any orders; and as part of processing an order, they were to contact the resident and/or their substitute decision maker (SDM) for notification of the order and obtain consent. RPN #116 reviewed the identified orders from August 2019, and confirmed that neither order had been checked off to identify that resident #001's SDM was notified.

During an interview with RPN #105, they reported to Inspector #621 that they were still learning about the home's processes, and did not think that the resident, the SDM or designate needed to be notified for every new order or change in order. However, RPN #105 did identify that they were aware that for resident #001, the SDM and/or their named designate were to be notified for all changes to the plan of care, including medication changes.

During a review of the home's Medication Management policy LTC 11-00, which included the pharmacy service provider's policies, effective September 24, 2018, it identified that processing an order included the resident or legal representative being informed of the new medication/procedure being prescribed.

During an interview with Clinical Manager #100, they reported that the home had received written consent from resident #001's SDM to have the complainant be contacted for care decisions, and that it was expected that when processing orders, that registered staff notified the complainant so that they were fully involved in the resident's plan of care. [s. 6. (5)]

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 resident, resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu,
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each menu, provided for a variety of foods, including fresh seasonal foods, each day, from all food groups in keeping with Canada's Food Guide as it exists from time to time.

A complaint was received by the Director on a day in September 2019, which identified concerns about the food quality in the home.

During an interview with resident #005, they reported to Inspector #621 that the home's menu did not have a lot of variety, with the same menu items served over and over.

During a review of the home's posted cycle menu, Inspector #621 identified that the breakfast choices listed, included the same hot cereal, main protein choice, toast and fruit option, each day, over the entire four weeks, (with exception of the toast option on Thursdays being a carrot muffin, and Saturdays being raisin toast). These main breakfast choices included:
Oatmeal
Boiled Egg

Whole Wheat Toast
Mandarin Oranges
During an interview with the Interim Food Services Manager (Interim FSM), they provided a copy of the home's four week Spring/Summer menu to the Inspector. On further review of the breakfast menu, the Interim FSM questioned if they had provided the Inspector the most current copy of the home's menu and went to investigate further.

On a follow up interview, the Interim FSM confirmed that the menu that they provided to the Inspector, was the home's current menu, and developed by their company's corporate head office. The Interim FSM reviewed the details of the breakfast menu with the Inspector and confirmed that the same first choice menu options repeated daily throughout the four week menu, and if followed by the home's food services staff, would not provide variety consistent with Canada's Food Guide. The Interim FSM also confirmed that in order to provide more variety in lieu of the first choice breakfast options listed, it would require menu substitutions that could impact inventory management and accuracy of the menu's nutrition analysis.

During an interview with the home's Food Production Supervisor, they reported that in follow up to resident requests for more menu variety, such as the inclusion of pancakes at breakfast, that the home was in the process of incorporating such requests into the upcoming Fall/Winter menu. [s. 71.(2) (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 each menu, provides for a variety of foods, including fresh seasonal foods, each day, from all food groups in keeping with Canada's Food Guide as it exists from time to time, to be implemented voluntarily.

WN #3: 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: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service which included food and fluids being served at a temperature that was safe and palatable to the residents.

A complaint was received by the Director on a day in September 2019, which identified concerns about the food temperatures during meal service in the home.

During an interview with Dietary Aide #111 during breakfast meal service on September 24, 2019, they reported that food temperatures were taken within a 15 minute window prior to the start of each meal service for the main menu items being served for regular, minced and pureed textures. Dietary Aide #111 reported that the Dietary Aide on day shift, for Third Floor North, took temperatures for both the north and south side servery stations; and the south side Dietary Aide took temperatures of both servery stations prior to the lunch meal service. Further Dietary Aide #111 reported that food temperatures were taken using a Bio Temp Thermometer, and recorded on the "Servery Temperature Form", located in the servery "Food Temperature Binder". When the Inspector inquired as to what the expected safe hot and cold holding temperatures were, they reported that hot foods were to be at a temperature at or above 140 degree Fahrenheit and cold temperatures at or below 40 degrees Fahrenheit.

On review of the Food Temperature Binder for the Third Floor servery area, the Inspector found completion of a temperature log for the morning of September 24, 2019, with temperatures recorded within safe hot holding range that was equal to or greater than 140 degrees Fahrenheit (60 degrees Celcius), for the hot cereal and eggs in regular, minced and pureed textures, as well as pureed toast. However, when Inspector #621 completed a temperature check during meal service of the same menu items from the Three North servery, it was found the regular boiled eggs had a hot holding temperature of only 133 degrees Fahrenheit. Dietary Aide #111 observed the temperature reading; confirmed that the reading was low, and reported that they completed temperature

checks at the start of a meal service, and were not required to complete them again later in the service.

On further review of the Third Floor temperature logs for September 20, 21, 22 and 23, 2019, the Inspector also found temperature records had not been documented for the following meals times and diet textures:
Lunch Meal - September 20, 2019 - no temperatures recorded for regular menu items for the Three North servery;
Dinner Meal - September 20, 2019 - no temperatures recorded for regular menu items for the Three North servery, or pureed items for the unit;
Lunch Meal - September 21, 2010 - no temperatures recorded for regular menu items for the Three North servery, or pureed items (with exception of the pureed soup); and
Lunch Meal - September 23, 2019 - no temperatures recorded for regular menu items for the Three South servery.

It was noted that temperatures were not taken of cold dessert items for five of eight (63 percent) of lunch and supper meals or temperatures of the milk beverage for 12 out of 15 (80 per cent) of breakfast, lunch and supper meals from September 20 to 24, 2019.

During a review of the lunch meal service on September 24, 2019, on the Third Floor, Dietary Aide #115 reported that they had completed temperature checks for both the north and south sides of the servery prior to meal service, and confirmed the menu items for lunch included regular and texture modified items of the following:
White Bean Soup
Chicken Salad Sandwich
Carrot Pineapple Salad
Greek Pizza
Grilled Vegetables
Fresh Fruit Salad
Cherry Jello

The Inspector reviewed the September 24, 2019 temperature log for lunch and identified that the log item referred to as "Cold Entrée 2", had recorded temperatures of 44, 43 and 41 degrees Fahrenheit for Three North regular, minced and pureed textures; and the log item identified as "Side 1 cold" had recorded temperatures of 43, 43 and 41 degrees Fahrenheit for Three North regular, minced and pureed textures respectively. When the Inspector inquired what "Cold Entrée 2"and "Side 1 cold" were for the lunch meal service, Dietary Aide #115 reported that they were the chicken salad sandwich and carrot

pineapple salad respectively.

While residents were still being served at 1230 hrs, Inspector #621 took temperatures using the Bio Temp Thermometer and found the regular chicken salad sandwich with a meat filling recorded a temperature of 46 degrees Fahrenheit; the carrot pineapple salad with a milk base component to it, recorded a temperature of 52 degrees Fahrenheit, and the Greek Pizza recorded a temperature of 130 degree Fahrenheit.

During an interview with Dietary Aides #111 and #115, they confirmed that the temperatures that were taken of the cold menu items which were greater than 40 degrees Fahrenheit, were out of the safe temperature range; and the hot items, which recorded temperatures less than 140 degrees Fahrenheit, were also out of the safe hot holding range. Additionally, when the Inspector asked what dietary staff were to do if they found temperatures out of the safe range at the start of meal service, they reported that they were to notify the Food Services Supervisor of the issue, so they could come to the unit and correct the temperature deficiencies with the identified food item(s). When the Inspector inquired whether the Food Services Supervisory staff were notified of the boiled eggs at breakfast or the menu items from lunch service that were found with temperature readings outside of a safe temperature range, Dietary Aides #111 and #115 reported that they had not notified their supervisors.

During an interview with the Interim FSM, they reported that it was their expectation that temperature logs had a record of temperatures for all first and second choice menu items; both hot and cold items, including milk beverages. They also reported that it was their expectation that when temperatures were found within an unsafe temperature range between 40 and 140 degrees Fahrenheit, that the Dietary Aide who took the temperatures, notified the Food Services Supervisor or Food Production Supervisor immediately, so that the menu item could be brought back into a safe holding temperature before being served to residents. The Interim FSM reported that food temperature logs were gathered from the serveries on a monthly basis and were to be reviewed and maintained by the Food Services Manager. However, they identified that they were unsure if anyone had been reviewing them up until the time of the inspection. [s. 73. (1) 6.]

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 which includes food and fluids being served at a temperature that is safe and palatable to the residents, to be implemented voluntarily.

WN #4: 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 drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was received by the Director on a day in September 2019, where concerns were identified that the home had not obtained consent to change a specific medication order. During an interview with the complainant, they reported that they had found the resident during a visit, to be in a particular condition. They reported that on review of the medication orders, it was identified that a new order had been made for a certain medication, and they they had not been made aware of the new order, and would have not consented to it.

During a review the resident #001's healthcare record, the Inspector identified a medication order processed on a specific date in August 2019.

A review of the August 2019 Medication Administration Record (MAR), indicated that on another specific date in August 2019, the RPN on duty had not administered the medication consistent with the prescriber's order.

During an interview with Clinical Manager #100, they reported that there had been a meeting with the complainant and the resident's substitute decision maker (SDM) on a specific date in August 2019, to discuss the resident's care management. The Clinical Manager thought there had been agreement reached to adjust a specific medication to assist with care, but confirmed that after a specified period or time after the meeting, they had talked with the complainant who denied that there had been consent given for the medication change.

On review of the August 2019 MAR with the Inspector, Clinical Manager #100 reviewed information pertaining to the order on the MAR, as well as the physicians order that was processed by registered staff on a specific date in August 2019, and confirmed that the medication had not been administered consistent with the prescriber's orders on a later date in August 2019. [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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint was received by the Director on a date in September 2019, which identified concerns about food temperatures and food quality in the home.

During a review of the breakfast menu on home area Three North, the posted menu for Week One, Tuesday identified that the planned menu consisted of the following:
Assorted Juices
Oatmeal or Assorted Cold Cereal
Boiled Egg or Peanut Butter
Whole Wheat Toast or White Toast
Mandarin Oranges

During an interview with Dietary Aide #111, they reported that they were serving breakfast as per the menu for Week One, Tuesday, which consisted of hot oatmeal, boiled eggs, toast and bananas. When the Inspector inquired if there were any mandarin oranges, Dietary Aide #111 reported that only bananas were available that morning.

During an interview with the Interim FSM, they reported that food services provided meal service consistent with the planned menu. When they reviewed the planned menu, the Interim FSM confirmed that mandarin oranges were the fruit option that was to be offered daily across the four week cycle menu for breakfast. When the Inspector inquired why bananas were offered instead, the Interim FSM reported that they would have been provided only on special request to residents who wanted them instead of the mandarin oranges. Further, the Interim FSM confirmed that if bananas were served as the only fruit option at breakfast, then food services had not prepared and made available to residents all menu items according to the planned menu. [s. 72. (2) (d)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

A Critical Incident System (CIS) report was received by the Director on a date in September 2019, concerning suspicions of staff to resident abuse of resident #001. The CIS report identified that the resident's substitute decision maker (SDM) brought forward concerns to Clinical Manager #100, identifying that they believed a specific care activity had been provided between two specific dates in September 2019, causing injury.

On review of resident #001's care documentation in Sept 2019, it was identified that PSW #119 recorded on a specific shift, for a particular date and time in September 2019, that they had completed a certain care activity. On review of the home's investigation notes, an interview by Clinical Manager #100 with PSW #119, identified that the PSW stated that they had only checked that the care had been done, and had not completed the care activity in question. The PSW indicated that they documented in error, that the care activity had been provided.

During an interview with resident #001, they denied that staff completed a specific care activity with them; that they completed the care activity themselves; and that the injury observed on a particular location of their body, was a result of something that they had done, not staff.

During an interview with Clinical Manager #100, they reported to Inspector #621 that their investigation determined that the last time a certain care activity had been completed with resident #001 was on a specific date in September 2019, by PSW #101. They reported that PSW #119 had documented in error that they provided the care a later date in September 2019, when they had not. Clinical Manager #100 confirmed that resident #001's written record had not been up-to-date with the correct information at the time of inspection. [s. 231. (b)]

Issued on this 10th day of October, 2019

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

Original report signed by the inspector.