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

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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 29, 2019	2019_538144_0001	020821-19	Complaint

Licensee/Titulaire de permis

The Corporation of the Municipality of Chatham-Kent
519 King Street West CHATHAM ON N7M 1G8

Long-Term Care Home/Foyer de soins de longue durée

Riverview Gardens
519 King Street West CHATHAM ON N7M 1G8

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

CAROLEE MILLINER (144)

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): October 7, 8, 9, 2019.

The following intake was inspected within this inspection:
Log 020821-19, IL-70341-LO related to bathing and staffing shortages.

During the course of the inspection, the inspector(s) spoke with five residents, two family members, the Director of Senior Services, Director of Care, Medical Secretary, one Registered Nurse, two Registered Practical Nurses and two Personal Support Workers.

During the course of the inspection, the inspector observed sixteen residents, reviewed sixteen resident clinical records, the home's 2019 staffing plan, the home's electronic staffing program, the Point of Care question report and the home's missed bath record.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that seven residents of the home were bathed, at a

minimum, twice a week by the method of their choice.

One complaint intake included a concern that staffing shortages were adversely affecting resident care and that resident baths were not being completed.

Review of the clinical record for one resident and Point of Care (POC) revealed that the residents plan of care included the days of the week the resident would be bathed and that the resident did not receive their baths as directed in their plan of care during the period of review by the inspector.

Review of the Personal Support Worker (PSW) staffing schedule confirmed that the nursing unit the resident resided on was short staffed during the shifts on the dates the resident did not receive their baths.

Review of the clinical record for a second resident and POC revealed that the residents plan of care included the days of the week the resident would be bathed and that the resident did not receive their baths as directed in their plan of care during the period of review by the inspector.

Review of the PSW staffing schedule confirmed that the nursing unit the resident resided on was short staffed during the shifts on the dates the resident did not receive their baths.

Review of the clinical record for a third resident and the POC question revealed that the Residents plan of care included the days of the week the resident would be bathed and that the resident did not receive their baths as directed in their plan of care during the period of review by the inspector.

Review of the PSW staffing schedule confirmed that the nursing unit the resident resided on was short staffed during the shifts on the dates the resident did not receive their baths.

Review of the clinical record for a fourth resident and the POC revealed that the residents plan of care included the days of the week the resident would be bathed on and that the resident did not receive their baths as directed in their plan of care during the

period of review by the inspector.

Review of the PSW staffing schedule confirmed that the nursing unit the resident resided on was short staffed during the shifts on the dates the resident did not receive their baths.

Review of the clinical record for a fifth resident and POC revealed that the residents plan of care included the days of the week the resident would be bathed and that the resident did not receive their baths as directed in their plan of care during the period of review by the inspector.

Review of the PSW staffing schedule confirmed that the nursing unit the resident resided on was short staffed during the shifts on the dates the resident did not receive their baths.

Review of the clinical record for a sixth resident and POC revealed that the residents plan of care included the days of the week that the resident would be bathed and that the resident did not receive their baths as directed in their plan of care during the period of review by the inspector.

Review of the PSW staffing schedule confirmed that the nursing unit the resident resided on was short staffed during the shifts on the dates the resident did not receive their baths.

Review of the clinical record for a seventh resident and POC revealed that the residents plan of care included the days of the week that the resident would be bathed and that the resident did not receive their baths as directed in their plan of care during the period of review by the inspector.

Review of the PSW staffing schedule confirmed that the nursing unit the resident resided on was short staffed during the shifts on the dates the resident did not receive their baths.

Two PSW's, two Registered Practical Nurses (RPN) and one Registered Nurse (RN) said that resident baths are missed due to staffing shortages.

The three identified PSW's and RN further explained that when the unit is short staffed, the Medical Secretary (scheduler) will ask PSW's working a short shift to extend their hours or call in additional staff for the following day to complete resident baths that had not been provided.

One RN shared that the staffing shortages had been brought to the attention of management approximately six weeks ago.

The Medical Secretary explained the home's scheduling program to the inspector and advised that in order to ensure the nursing department is staffed according to their 2019 staffing plan, they ask PSW's working short shifts to extend their hours of work and call in additional staff for days following staff shortages.

The Director of Care (DOC) confirmed their knowledge of the staffing shortages however, was not aware of the number of resident baths that had not been provided.

The DOC advised that recently, PSW weekend short shifts had been extended to full shifts and that to date in 2019, the home has hired 13 PSW??s and 11 PSW students.

The DOC further advised that recruitment advertisement is posted on an ongoing basis on the municipal job board and that the home has participated in two community job fairs this year. [s. 33. (1)]

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 resident of the home is bathed, at a minimum, twice a week by the method of his or her choice,, to be implemented voluntarily.

Issued on this 29th day of October, 2019

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

Original report signed by the inspector.