Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 3, 2016	2016_391603_0023	025047-16, 026245-16, 026968-16, 029022-16	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 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

SYLVIE LAVICTOIRE (603), LISA MOORE (613)

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 11-14, 17-21, 2016.

This Complaint inspection was related to three intakes regarding the care of residents and one intake regarding the condition of the home.

A Follow Up Inspection #2016_391603_0024 and a Critical Incident Inspection #2016_391603_0022 were conducted concurrently. Non-compliance regarding s. 6. (9)1 was identified in Critical Incident Inspection #2016_391603_0022 and the findings were issued in this report.

During the course of the inspection, the inspector(s) directly observed the delivery of resident care, staff to resident interactions, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed various home policies, procedures, and programs, and reviewed staff education attendance records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Client Care Coordinator, Clinical Managers, Resident Assessment Instrument (RAI) Coordinators, Maintenance Supervisor, Environmental Services Supervisors, Staffing Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Staff, residents, and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Personal Support Services
Reporting and Complaints
Sufficient Staffing

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

4 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	Legendé 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

a) Inspector #613 reviewed a complaint submitted to the Director identifying that resident #012 did not receive their scheduled bath on a certain date, and was not receiving their scheduled baths twice a week.

The Inspector reviewed resident #012's health care record. The bathing assignment sheets indicated that the resident was to receive their scheduled baths on two specific days, during the week. The current plan of care revealed that resident #012 preferred a specific bath, at a certain time of the day. The Flow Sheets that were completed by the Personal Support Workers (PSWs) on the electronic documentation Point of Care (POC), were provided to the Inspector by Resident Assessment Instrument (RAI) Coordinator #108. The Inspector reviewed the Flow Sheets for a specific two and half months, which revealed that many scheduled bath dates had no documentation. The first month, there were four dates with no documentation to demonstrate a bath was provided, not provided or refused; the next month, there were four dates with no documentation to demonstrate a bath was provided, not provided, or refused; and in the last month, there was one date with no documentation (for the first 12 days) to demonstrate a bath was provided, not provided, or refused.

b) Inspector #613 reviewed a complaint submitted to the Director, identifying that resident #015 did not receive their scheduled bath on a certain date, and was not receiving their scheduled baths twice a week due to staffing shortages.

The Inspector reviewed resident #015's health care record. The bathing assignment

sheets indicated that the resident was to receive their scheduled baths on two specific days. The current plan of care revealed that resident #015 preferred a specific bath, at a certain time of the day. The Flow Sheets that were completed by the PSWs on the electronic documentation POC were provided to Inspector by RAI Coordinator #108. The Inspector reviewed the Flow Sheets for a specific two and half months, which revealed that many scheduled baths dates were not documented. In the first month, there were five dates with no documentation to demonstrate a bath was provided; in the second month, there were two dates with no documentation to demonstrate a bath was provided; and in the last month, there were three dates with no documentation (for the first 12 days) to demonstrate a bath was provided.

c) Inspector #613 also reviewed a complaint submitted to the Director, identifying that resident #012 did not receive oral care on a routine basis.

The Inspector reviewed resident #012's health care record. The most recent care plan accessible to staff identified that the resident was to have specific oral care after each meal. The Flow Sheets that were completed by the PSWs on the electronic documentation (POC) were provided to the Inspector by the RAI Coordinator #108. The Inspector reviewed the Flow Sheets for a specific two and half months, which revealed many dates with no documentation from the PSWs and inconsistencies with documentation, for mouth care. In the first month, there were seven dates with no documentation for the day or evening shift to demonstrate that oral care was provided; in the second month, there were three dates with no documentation for the day or evening shift to demonstrate that oral care was provided; and in the last month, there were two dates (for the first 12 days) with no documentation for the day or evening shift to demonstrate oral care was provided.

Inspector #613 interviewed PSW #106, who explained that it was the home's expectation that PSWs document all care provided to the resident in POC.

The Inspector also interviewed Clinical Manager #110 and the ADOC, who explained that it was their expectation that PSWs documented the resident care provided in POC. Clinical Manager #110 also stated that some PSWs have had a problem completing documentation as per expectations. [s. 6. (9) 1.]

2. Inspector #616 reviewed a Critical Incident (CI) Report submitted to the Director, alleging resident to resident physical abuse on a specific date. The incident was initially reported to the Long-Term Care Emergency Pager, three days earlier, the day of the

incident.

The Inspector reviewed resident #002's plan of care which related responsive behaviours. An order was made by the physician on a certain date, for specific medication changes as well as Dementia Observation System (DOS) monitoring for two weeks. The Inspector located a two page DOS record for the next two weeks, after the physician order. Documentation was to be recorded in half hour intervals, with numbers for corresponding behaviours demonstrated by the resident. Over the 14 day review period, documentation was incomplete on nine days, or 64 percent.

A progress note dated the day after the physician order, revealed that DOS was started on this date. The Inspector further reviewed the progress notes for any noted responsive behaviours correlating to the dates and times on the DOS where documentation was incomplete. There were five separate incidents where documented behaviours were not documented on the resident's DOS as ordered by the physician.

During an interview with PSW #115 and RPN #116, they explained that at that time, there was not one staff member responsible to complete the DOS as ordered for resident #002. RPN #116 reviewed the DOS forms with the Inspector for the same two weeks and explained that the blank documentation throughout the review period indicated that staff did not document the monitoring of this resident and should have. [s. 6. (9) 1.]

3. Inspector #616 reviewed a CI submitted to the Director, which was related to resident to resident abuse on a certain date.

The Inspector reviewed the home's investigation record and a DOS form had been initiated to monitor resident #027's behaviours for one week, beginning the next day after the CI. Behaviour documentation was incomplete five out of seven days.

During an interview with Clinical Manager #118, they explained that one of the actions in response to this reported incident was that registered staff initiated and recorded behaviours through DOS monitoring. Clinical Manager #118 further explained that this documentation should have been completed fully on each day of the monitoring period.

During an interview with RPN #119, they verified the DOS monitoring record was included in resident #027's plan of care, and should have been completed fully by registered staff. [s. 6. (9) 1.]

4. Inspector #616 reviewed a CI submitted to the Director, which was related to resident to resident abuse on a certain date.

The Inspector reviewed the home's investigation record. As an immediate action documented in the Safety Report Details for resident #008, a DOS form had been initiated to monitor behaviours for one week, beginning the same day of the CI. Behaviour documentation was incomplete seven of seven days.

During an interview with Clinical Manager #137, they explained that the registered staff were responsible to ensure that PSW staff completed the documentation of behaviour monitoring for resident #008 on the DOS form. Clinical Manager #137 also explained that this documentation should have been completed fully on each day of the monitoring period. [s. 6. (9) 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 ensuring that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #613 reviewed a complaint submitted to the Director, identifying that resident #015 did not receive their scheduled bath on a specific date, and was not receiving their scheduled baths twice a week due to staffing shortages.

The Inspector reviewed resident #015's health care record. The bathing assignment sheets indicated that the resident was to receive their scheduled baths on two specific days during the week. The current plan of care revealed that resident #015 preferred to have a certain bath and baths were to be done at a certain time of the day. The Flow Sheets that were completed by the PSWs on the electronic documentation (POC) were provided to the Inspector by RAI Coordiantor #108, and indicated that the resident did not receive a bath on the day of the complaint.

Inspector #613 interviewed Scheduling Coordinator #127, who explained that the home did not have a full complement of PSWs on the resident's scheduled bath day mentioned in the complaint.

The Inspector reviewed the home's complaint investigation file which identified that the home was also short staffed a PSW on the next day. Resident #015 did not receive a bath on their scheduled day or on the next day. A bath was finally provided to the resident, two days after the scheduled bath.

Inspector #613 interviewed Clinical Manager #110, who revealed that a new PSW #130 was working on that specific day (the day of the complaint), and missed providing resident #015 their scheduled bath, and PSW #130 did not consult with the team to inform that they were behind with their work assignment. Clinical Manager #110 explained that it was their expectation that baths were provided twice per week, as per the resident's care plan, and when short staffed, the team (RNs, RPNs, and PSWs) was to work as a team and strategize to ensure resident baths were provided.

Clinical Manager #110 also provided the Inspector with a Newsletter, that identified resident bathing was not optional, and revealed that on weekends, staff were challenged, worked short, and sometimes omitted bathing residents due to time constraints. [s. 8. (1) (b)]

WN #3: 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 the residents of the home were bathed, at a minimum, twice per 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.

Inspector #613 reviewed a complaint submitted to the Director, identifying that resident #012 did not receive their scheduled bath on a specific date, and was not receiving their scheduled baths twice a week.

The Inspector reviewed resident #012's health care record. The bathing assignment sheets indicated that the resident was to receive their scheduled baths on two specific days. The current plan of care revealed that resident #012 preferred to have a certain bath and baths were to be done at a certain time of the day. The Flow Sheets that were completed by the PSWs on the electronic documentation (POC) were provided to the Inspector by the RAI Coordinator #108, indicated that resident did not receive a bath on that specific date (the date identified in the complaint). The resident received only one bath during that week.

The Inspector interviewed the Scheduling Coordinator #127, who explained that the home did have a full complement of PSWs on the resident's scheduled bath day.

The Inspector interviewed Clinical Manager #110, who explained that it was their expectation that residents receive a bath twice a week as per their care plans. [s. 33. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (1) As part of organized programs of housekeeping and maintenance services under clauses 15 (1) (a) and (c) of the Act, every licensee of a long-term care home shall ensure that an organized preventive pest control program using the services of a licensed pest controller is in place at the home, including records indicating the dates of visits and actions taken. O. Reg. 79/10, s. 88 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an organized preventive pest control program using the services of a licensed pest controller is in place at the home, including records indicating the date of visits and actions taken.

Inspector #613 reviewed a complaint submitted to the Director identifying that there was a pigeon problem at the home. The pigeons were roosting in a covered area, over the main entrance of the building, and their droppings were on the ground where residents sit or enter the home.

During the two week inspection, Inspectors #613, #603, and #616 observed large amounts of pigeon droppings at the home's entrance way and on the grounds where the residents' sitting area was located. The Inspectors observed residents who were ambulatory or in wheelchairs, walking around or through the pigeon droppings.

On October 13, 2016, Inspector #613 met with Maintenance Supervisor #122 who stated they had not been in contact with the services of a license pest controller for the main entrance; however, they had been in contact with a licensed pest controller only for the balconies of the home, where there was also a pigeon problem. Maintenance Supervisor #122 explained that the ground to the main entrance and residents' sitting area were power washed every two weeks, to remove the pigeon droppings.

On October 19, 2016, Inspector #613 interviewed the Acting Director of Care, who acknowledged that the pigeons and their droppings were a problem for the main entrance and the residents' sitting area. [s. 88. (1)]

Issued on this 8th day of November, 2016

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

Original report signed by the inspector.