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 prévue le Loi de 2007 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


## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 27, 2017; | 2017_509617_0018 (A1) | 011881-17, 014564-17, 015832-17, 016286-17 | 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

RYAN GOODMURPHY (638) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**Compliance Order #001 and #002, compliance due date extended until February 28, 2018.**

**Issued on this 27 day of December 2017 (A1)**

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

**Original report signed by the inspector.**

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 prévue le Loi de 2007 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

## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 27, 2017; | 2017_509617_0018 (A1) | 011881-17, 014564-17, 015832-17, 016286-17 | 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

RYAN GOODMURPHY (638) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

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

**This inspection was conducted on the following date(s): August 14-18; August 21-25; and August 28-September 1, 2017**

**This Complaint Inspection was conducted as a result of the following complaints submitted to the Director:**

**-three complaints related to resident personal care, and**

**-one complaint related to the functioning of the elevator and fire alarm systems.**

**A Follow Up inspection #2017_509617_0019, and Critical Incident System (CIS) Inspection #2017_509617_0017, were conducted concurrently with this Complaint Inspection. Non -compliance pursuant to LTCHA, 2007, S.O. 2007, c.8, s. 6 (1) c and s. 6 (7), identified from the concurrent CIS inspection #2017_509617_0017, will be issued in this Complaint inspection.**

**The inspectors conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, various staffing schedules, observed resident common areas, and observed the delivery of resident care and services, including staff to resident interactions.**

**During the course of the inspection, the inspector(s) spoke with the Vice President of People, Mission, Values (VP), Director of Care (DOC), Clinical Managers (CMs), the Interim Maintenance Manager, Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) Coordinators (RAI Coord), Physiotherapists (PTs), a Physiotherapy Aid (PTA), Registered Dietitians (RDs), Scheduling Coordinator, Scheduling Clerk, Pay Roll Clerk, Recreational Therapist (RT), a Security Guard, family members and residents.**

**The following Inspection Protocols were used during this inspection:**

**Continence Care and Bowel Management**

**Minimizing of Restraining**

**Nutrition and Hydration**

**Pain**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Reporting and Complaints**

**Responsive Behaviours**

**Safe and Secure Home**

**Skin and Wound Care**

**Sufficient Staffing**

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

- **6 WN(s)**
- **5 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**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).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #028 as specified in their plan.

Inspector #617 reviewed a complaint received by the Director regarding resident #028's care needs.

In an interview with the complainant they reported that on three separate occasions staff were not familiar with the care needs of resident #028, and did not provide the appropriate approach to assist the resident with their specific care needs. The complainant further explained that resident #028, if not approached in a consistent manner as identified by their care plan, would refuse care.

A review of resident #028's Resident Assessment Instrument Minimal Data Set (RAI MDS), indicated that they were resistant to care, and required the assistance of staff for a number of specific interventions.

A review of resident #028's care plan, identified interventions for the provision of care and that staff were required to:
-introduce themselves each time they approached the resident,

-resident preferred care from specific staff members,
-resident would refuse when approached for personal care. Staff were instructed to use gentle persuasive approach for compliance and re-approach if necessary,
-complete night time care no earlier than 1900hrs,
-resident retired to bed around 1930-2000hrs, and
-remind the resident of meal times five minutes before it started.

On August 17, 2017, at 1618hrs, Inspector #617 observed resident #028 lying in their bed. Resident #028's family member was sitting at the bedside visiting. PSW #116, walked into the room, did not address the resident, proceeded to remove their covers and stated repeatedly, "time for pyjamas" to the resident and their family member. Resident #028's family member spoke to the PSW and said it was too early to put the resident into pyjamas and that it was too early to assist them to the dining room for their dinner, after which the staff member left the resident's room.

Then on August 17, 2017, at 1650hrs, Inspector #617 observed both PSW #157, and PSW #116 enter resident #028's room, and asked the resident if they wanted to come to the dining room for dinner. The resident responded with "no". The resident's family member asked the PSWs to come back in five minutes to assist the resident to the dining room.

A review of the dining schedule indicated that dinner was offered at 1700hrs.

Inspector #617 observed the August 17, 2017, dinner meal service, which identified that the first course of soup was offered at 1708hrs. The Inspector observed three PSWs working on the unit at the time and there were two female PSWs and one male PSW.

In an interview with PSW #116 both the Inspector and PSW #116 reviewed resident #028's care plan regarding the resident's specific needs for personal hygiene. PSW #116 confirmed to the Inspector that they did not provide care to the resident as specified in their plan in relation to not identifying themselves when they walked into the room, and inappropriately offered night time care three hours too soon.

Inspector #617 interviewed PSW #157 who confirmed to the Inspector that they did not provide care as specified in their plan related to assisting resident #028 too soon to the dining room and the resident's preference to be cared for by specific

staff members was not provided, triggering their refusal to receive care, and their resulting distress.

2. Inspector #616 observed resident #003 on August 16, 18 and 21, 2017, with a focus on falls prevention interventions and strategies, as they had sustained three falls with significant injury since their admission, with three falls requiring substantial medical intervention.

The Inspector reviewed the resident's current care plan where they were identified as at risk for falls related to the three falls causing the need for substantial medical intervention. The care plan identified interventions for falls prevention that included the use of a monitoring device and staff were to respond to resident #003’s monitoring device immediately.

On two occasions (August 16 and 21, 2017) resident #003 was observed by the Inspector not having the monitoring device in place.

On August 21, 2017, the Inspector interviewed PSW #118 who reported that resident #003 was known to be at risk for falls. They stated that they were aware that the monitoring device was one of the interventions identified in their plan of care to prevent the resident from falling; however, they forgot to utilize the monitoring device that day.

On August 18, 2017, the Inspector observed resident #003, seated in their wheelchair in the corridor outside their room, when the monitoring device was activated. The Inspector noted that the device was activated for five minutes before PSW #119 was observed to walk at an unhurried pace toward the resident’s room, at which time they deactivated the device.

During interviews with RPN #120 and PSW #119, they both reported that resident #003 was known to be at risk for falls; both stated they were aware the resident’s monitoring device had been activated on August 18, 2017. Both the RPN and PSW verified that it was the responsibility of all staff to respond immediately to the activation of resident #003’s monitoring device.

RN #111 verified to the Inspector that on August 16, 2017, prior to lunch service, resident #003 did not have their monitoring device in place as required. They verified that the monitoring device was to be used at all times as a safety intervention listed in the resident’s Kardex.

During an interview with CM #136, they stated that resident #003 was at risk for falls. They stated that is was the expectation of staff that they respond immediately to the activation of monitoring devices, and that the monitoring device was to be in place as per the care plan.

3. A Critical Incident report was received by the Director, concerning resident #004's fall, and resulting injury.

Inspector #577 reviewed resident #004's care plan, which instructed staff to ensure that the resident's call bell was within reach at all times and specific fall interventions were in place; staff were to ensure the resident's requirement for transfers, ensure all staff were informed, and make note at the bedside of the requirement.

During two observations on August 25, 2017, Inspector #577 observed the following:
-at 1115 hours, (hrs) the call bell in resident #004's room was lying on the floor, and the specific fall intervention was not initiated. Resident #004 was sitting on the side of their bed attempting to self-transfer. The Inspector noted a missing transfer logo at the bedside, and
-at 1325 hrs, resident #004 was lying in bed, their call bell was on the floor and the specific fall intervention was not initiated.

On that same day at 1340 hrs, CM #138 and the Inspector entered resident #004's room where they observed the call bell on the floor, the specific fall intervention was uninitiated, and the transfer logo was not present.

The CM confirmed with the Inspector that staff were not providing care as specified in the care plan.

4. The home submitted a Critical Incident report to the Director regarding resident-to-resident physical abuse. The CI report indicated that on a specific date, during the evening, RPN #130 witnessed a physical altercation between resident #037 and resident #040. The RPN separated the residents and discovered that resident #040 had been injured.

In an interview with RPN #130, they confirmed to Inspector #617 that they witnessed resident #040 and resident #037 engaged in a physical altercation on a

specific day. The RPN reported that resident #040 was assessed to have sustained an injury.

In that interview, RPN #130 further explained to the Inspector that resident #037 required heightened observation in the form of increased monitoring, due to responsive behaviours.

A review of resident #037's RAI MDS, relevant to the time of the critical incident, indicated that they were assessed to have physically abusive and socially inappropriate behaviours, which were not easily altered.

A review of resident #037's care plan indicated that the resident had interventions for responsive behaviours.

A review of resident #037's physician's order indicated that the resident was to attend a specific program at the home and continue to have increased monitoring during specific times. This was due to the resident's responsive behaviour and risk to resident safety.

In an interview with RPN #130 they confirmed to the Inspector that at the time of the incident on a specific date resident #037 did not have the required increased monitoring. RPN #130 explained that resident #037 did not attend the specific program that day, and was on the unit the entire time.

In an interview with Staffing Coordinator #180, they confirmed to the Inspector that there were no staff scheduled for the increased monitoring of resident #037. The staffing clerk further explained that they were directed from the CM #138, that they were not required to provide the increased monitoring during certain times, as the resident was attending a specific program.

On a specific date, on four separate occasions, while the resident was to receive increased monitoring, Inspector #617 observed resident #037 lying in bed sleeping in their room, and staff were not providing the increased monitoring.

In an interview with PSW #181, they reported to the Inspector that resident #037 was to attend a specific program on that day and was not feeling well. PSW #181 further explained that resident #037 had been awake and wandering most of the prior night and, as a result, was sleeping most of the day and had not gotten out of bed for breakfast or lunch.

In an interview with RT #182, they reported to the Inspector that resident #037 was to attend a specific program, seven days a week, and had not been in attendance over the last two weeks due to their illness.

In an interview with CM #138, they confirmed to the Inspector that resident #037 was required to attend a specific program and have increased monitoring during certain hours due to their responsive behaviours. CM #138 further confirmed that when resident #037 was not attending the specific program, they required increased monitoring when on the unit as per their plan of care. CM #138 explained that there had been a "disconnect" in communication. As a result, staff were unable to schedule and provide the care planned increased monitoring.

5. Inspector #617 reviewed a complaint received by the Director regarding staffing insufficiency in a specific home area, and the heightened monitoring of those residents with responsive behaviours.

In an interview with the complainant they reported to the Inspector that during an evening in a particular month, a specific unit was working short staffed and two residents, who were known to require increased monitoring due to their responsive behaviours, and the increased monitoring was not provided.

On August 18, 2017, Inspector #617 interviewed CM #165, who reported that for the entire particualr month on evening shifts, a specific home area required two PSWs to provide increased monitoring for both resident #034 and resident #032. CM #165 further explained that resident #034 required the increased monitoring to prevent a specific responsive behaviour.

A review of resident #034's RAI MDS, indicated that they were assessed as having responsive behaviours that were not easily altered. A review of the resident's care plan indicated that they required increased monitoring.

A review of resident #034's physician's orders, indicated to continue increased monitoring for patient safety.

A record review of resident #034's progress notes dated for the particular month, indicated that during nine evenings, the resident exhibited responsive behaviours due to not having increased monitoring.

In an interview with PSW #183, they reported to the Inspector that during the particular month, resident #034 required increased monitoring, as required in their care plan, to prevent them from displaying persistent responsive behaviours. PSW #183 explained that when the increased monitoring was not available, because the unit was short staffed, the resident would display specific behaviours. PSW #183 further confirmed to the Inspector that there were occasions, during the particlar month when the unit was short staffed; as a result, increased monitoring was not provided to resident #034 as required in their care plan.

In an interview with PSW #184, they reported to the Inspector that resident #034 required increased monitoring during specific times in the particular month, due to their responsive behaviours. PSW #184 explained that when resident #034 was left alone, and did not have increased monitoring, they would exhibit certain responsive behaviours. PSW #184 confirmed that when the increased monitoring was not provided to resident #034, their care was not provided, as required in their care plan.

6. The licensee has failed to ensure that the staff and others who provided direct care to resident #028 were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Inspector #617 reviewed a complaint received by the Director regarding resident #028's pain management.

In an interview with the complainant, they explained that on a specific date, resident #028 had been in pain. The complainant reported they had requested RPN #113 to administer resident #028 their, "unscheduled" pain medication to which the RPN refused, as they were not aware the resident had "unscheduled" pain medication. The complainant reported that the RN came to the unit and assisted RPN #113 to find and administer the "unscheduled" medication. The complainant was concerned that if they were not in the home at the time of the incident that RPN #113 would not have administered resident #028 their medication, as they were not aware of the resident's prescribed medications.

A review of resident #028's physician's orders and electronic Medication Administration record (eMAR) indicated that for the particular month, the resident was to be administered a specific pain medication when required or "unscheduled" for pain.

A review of resident #028's progress notes dated at the time of the incident, indicated that RN #143 had attended the unit, discussed the pain medication with the complainant, reviewed the resident's pain medication management, and directed RPN #113 to administer the medication for discomfort and, as indicated, to help them settle; and in their plan of care.

In an interview with RN #143, they confirmed that RPN #113 was not aware of resident #028's plan of care for the administration of unscheduled pain medication and required the RN's direction. RN #143 further explained that RPN #113 had difficulty navigating the eMAR to find resident #028's pain medication order and was known to have made medication administration errors.

In an interview with the DOC, they reported that RPN #113 was an agency nurse who no longer worked at the home. The DOC confirmed that RPN #113's work performance, regarding medication administration errors, was a concern to the home.

7. The licensee has failed to ensure that resident #004 was reassessed and the plan of care reviewed and revised at least every six months, and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A CI report was received by the Director concerning resident #004's fall and resulting injury.

During a record review of resident #004s care plan interventions, Inspector #577 found that staff were required to use a specific device for transfers.

Inspector #577 reviewed the most recent physiotherapist assessment, which indicated that the resident required a specific device, and was at high fall risk.

Inspector #577 conducted a record review of resident #004's progress notes. The most recent dated physiotherapy note indicated that they conducted a self-transfer safety assessment. The note further indicated that the resident was not safe for independent transfers, and staff were to continue to monitor and attend to client's call bell to ensure safety during their transfer.

Inspector #577 reviewed the care plan interventions for resident #004 with PSW #123, which indicated the use of a specific device for transfers. PSW #123

reported to the Inspector that they had never used the specific device to transfer the resident.

Inspector #577 spoke with PSW #162 and reviewed resident #004's Kardex and care plan with the PSW. The PSW reported that resident #004 they did not use the specific device for transferring the resident; however, the resident's care plan indicated the use of the specific device for transferring.

Inspector #577 spoke with PT #117 who reported that the resident was assessed as a supervised transfer. They communicated that change to the Registered Practical Nurse; however, the change in the resident's transfer status was not revised in their care plan.

8. The licensee has failed to ensure that resident #028 was reassessed and the plan of care reviewed and revised at least every six months, and at any other time when, care set out in the plan had no longer been effective.

Inspector #617 reviewed a complaint received by the Director regarding resident #028's pain medication administration.

In an interview with the complainant, they explained to the Inspector that resident #028, required a consistent approach by staff, and if not provided they would refuse to take their medications. The complainant further reported that on several occasions they had found medication tablets in various locations within the resident #028's room.

A review of resident #028's most current RAI MDS assessment, indicated that the resident resisted taking medications.

A review of resident #028's current care plan, and electronic Medication Administration Record (eMAR), all indicated that the resident was not compliant with medication administration. As an intervention, the care plan advised staff to provide a specific step by step to administer their medication successfully, as the resident tended to pocket their medication. The same step-by-step process was also posted in the medication room and on the medication cart.

On a specific date the Inspector observed RPN #155 administer two medication tablets to resident #028. RPN #155 was observed by the Inspector to not follow the specific steps as indicated in the resident's care plan, however; the RPN ensured

that the medication was swallowed.

The Inspector interviewed RPN #155 who explained that medication administration to resident #028 was challenging as they were known to refuse their medication. RPN #155 further explained that recently the resident's health had deteriorated. RPN #155 reported that since then, registered staff had been providing a different approach to administering resident #028's medication to prevent the resident from refusing the medication.

Inspector interviewed RPN #156, who reported they had administered medication to resident #028 in a different approach as indicated by the resident's care plan to prevent the resident from refusing the medication.

Both RPN #155 and RPN #156 confirmed to the Inspector that resident #028's current written plan of care regarding their medication administration required an update to the interventions. They indicated that it did not reflect the successful administration process being utilized to prevent the resident from refusing their medications.

***Additional Required Actions:***

**CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A1)The following order(s) have been amended:CO# 001**

***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 staff and others who provide direct care to resident #028 are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, and***

***-to ensure that resident #028 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has no longer been effective, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 31. (3) The staffing plan must,**
**(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).**
**(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).**
**(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).**
**(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).**
**(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).**

**Findings/Faits saillants :**

1. The home failed to ensure that their staffing plan promoted continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident.

Inspector #617 reviewed a complaint received by the Director regarding resident #028's continuity of care.

The Inspector interviewed the complainant who reported that on three separate occasions PSWs had asked them how to care for resident #028. On two separate occasions they had observed the resident had not been provided with proper care. The complainant voiced concern that the agency and new staff were not familiar with resident #028's care.

On two separate occasions during the inspection of the home, different resident family members had approached the Inspector to voice their concerns about the continuity lacking from the PSW staff, as the agency PSWs and new staff hired over the summer were not familiar with the residents' care needs.

Inspector reviewed the home's staffing plan titled, "Staffing Plan for SJCG Long Term Care Homes Bethammi and Hogarth Riverview Manor" dated August 2017. The home's written plan did not identify the promotion of continuity of care by minimizing the number of different staff members, who provided nursing and personal support services to each resident.

The Inspector reviewed the home's "Staffing Guidelines for the RNs, RPN's and PSW's at Hogarth River Manor" dated July 2016, which identified that staffing levels were based on predetermined staffing ratios for direct-care, workload, work environment, resident complexity, skill level of the staff, staffing mix, and, the availability of support staff and other team members. The staffing office was to collaborate with the unit RN staff to adjust work assignments based on the predetermined ratios, and the availability of resources on any shifts. The document also indicated that, as employees of the Care Group any/all could be assigned to work in all areas of the homes as the need arose.

On a specific date Inspector #617 observed PSW #116 had started their evening shift in a specific home area at 1500hrs and was told by RN #126 that at 1800hrs they were to move to a different home area to complete their shift there, because the unit had been short staffed and required help.

Inspector interviewed PSW #116 who reported that they were an agency staff member and rotated on all the units. PSW #116 explained that they did not have a permanent rotation on a unit, and the maximum amount of shifts they work on the

same unit was three consecutive shifts.

Inspector interviewed PSW #185 who reported that they had been hired in the past two months. PSW #185 explained that they had a designated unit; however, since their hire date, they had been scheduled on many different units, and worked no more than five consecutive shifts in a row on one unit.

In an interview with RN #143, they reported that due to staffing shortages, the registered staff had been required to move PSWs during a shift from one unit to another to help with PSW vacancies. As a result, residents had a number of PSWs caring for them who may not have been familiar with their care.

In an interview with the DOC, they confirmed to the Inspector that the home's written staffing plan for the programs did not promote continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident. The DOC reviewed the legislation and confirmed that the home did not provide continuity to the residents.

***Additional Required Actions:***

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

**(A1)The following order(s) have been amended:CO# 002**

---

**WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Inspector #620 reviewed a complaint that was received by the Director. The complainant alleged that residents' call bells were going unanswered for an extended period of time (30-40 minutes) before staff were responding. The complainant indicated that on some occasions staff wouldn't respond at all.

On August 16, 2017, at 0810 hours, Inspector #620 was reviewing clinical records in a specific home area Nursing Station. At this time Inspector #620 could hear active call bells sounding. A screen in the nursing station was displaying the time when the call bell had been initiated and the location of the call. The call bell for resident #016 was active and unanswered for 38 minutes. The call bell for resident #050 was active for 51 minutes before being answered.

Inspector #620 interviewed PSW #171 who was the PSW assigned to provide care for resident #016, and #050. They indicated that they had not heard the call bells sounding. PSW #171 also denied seeing the call activated call bells on the marquee. Inspector #620 inquired as to what resident #016 had requested for assistance. They indicated that resident #016 had requested a towel to put under their head.

Inspector #620 interviewed resident #016 and asked them why they had rung their call bell. They indicated that, "last night" they rang their call bell so that they could get a drink of water. They went onto describe that RPN #113 responded to their call bell and that when they arrived to their room they asked for a drink of water. They stated that they warned RPN #113 not to tip the cup because water would be spilled. They said that RPN #113 didn't listen; as a result, water was spilled into

their bed. They noted that RPN #113 put a towel under them to soak up some of the water then left the room; RPN #113 did not offer to change the wet bedding. Inspector #620 felt resident #016's bedding and mattress and confirmed that it was saturated with water.

Inspector #620 interviewed RPN #113 who indicated that they had put a towel under the resident's head. RPN #113 noted that the resident had told them that water had spilled, so they offered to put a towel under them. They denied offering to change the resident's bedding. They advised the Inspector that the resident was to receive a bed change when they were prepared for breakfast.

Inspector #620 interviewed RN #111 who indicated that both resident #016 and #050 had waited too long to have their care needs met. They also advised that resident #016 was at high risk for skin integrity concerns and that they should not have been left in a wet bed. They indicated that RPN #113 should have ensured that the bedding was changed immediately.

Inspector #620 interviewed Manager #136 and the DOC who indicated that the call bells had not been attended to in an appropriate amount of time. They indicated that resident #016's bedding should have been changed when the water was spilled. They indicated that RPN #113 showed poor clinical judgement and that they had been terminated as a result of this matter and other unrelated performance transgressions.

***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 every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.***

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment,
(ii) received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented, and
(iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #620 reviewed a complaint received by the Director. The complainant alleged that the home's PSWs were providing wound care for the residents, specifically to resident #016. They expressed concerns that registered staff were not doing weekly wound assessments.

Inspector #620 conducted a review of resident #016's clinical record. The record revealed that a physician's order was written, which required the treatment of a wound. The order required staff to treat the wound in a specific manner.

A review of the most recent physician's orders for the treatment of the wound for a four month period, revealed that the physician made four separate entries related to the treatment of the wound.

Further review of the resident's clinical record identified that resident #016's documented medication reconciliation reviews addressed the treatment of the resident's wound. The medication reconciliation document, advised staff to treat the wound in a specific manner; a note in the document also advised staff that the treatment did not appear in the electronic medication administration record (eMAR).

Inspector #620 conducted a review of the resident's eMAR and was unable to identify that the treatment for the wound was indicated or being documented within. A review was also conducted to ascertain whether weekly wound assessments were being conducted; the Inspector was unable to locate any such evidence. This Inspector was also unable to identify any record indicating that the prescribed treatment of the wound was occurring.

Inspector #620 reviewed a document titled, "Skin and Wound Care Program" dated July 2016. The document advised registered staff that upon the discovery of a wound, staff where expected to conduct weekly wound assessments, update the resident's plan of care outlining the treatment, and implement the established wound care interventions. The document also indicated that all wound care interventions and treatment outcomes were to be documented.

Inspector #620 reviewed resident #016's care plan. There was no entry within the resident's care plan that addressed the resident's wound.

Inspector #620 interviewed RPN #113 who indicated that they were unsure if resident #016 had a wound. They stated that they had never provided a treatment for the resident's wound. The inspector asked the RPN if the resident's wound treatment appeared on the eMAR; they said, it did not.

Inspector #620 interviewed RN #111 who indicated that if the resident had a wound, it may have been documented in the wound care binder. They stated that

there was no consistency with how wounds were documented and that it may have also been documented in the progress notes. RN #111 was asked if they could locate the resident's weekly assessments and documented treatments. RN #111 indicated that they were unable to find any such documentation.

Inspector #620 interviewed DOC #114 who indicated that resident #016 did have a wound requiring intervention. They indicated that for reasons unknown to them, the wound was not being assessed weekly or treated as required by the physicians order and the home's policy. They indicated that they were unable to determine how long the wound had been left untreated without assessment.

***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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,***

***(i) receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment,***

***(ii) receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,***

***(iii) assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented, and***

***(iv) reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.***

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

Inspector #616 observed three instances when residents' prescribed treatment medication was not stored securely or locked when not in use by staff.

On August 22, 2017, at 0940 hours, (hrs) in a specific home area, a clear plastic container with topical medications was observed by the Inspector to be unsupervised, on a care cart, stored against the door of a housekeeping room, between two resident rooms. Resident #001, was observed to ambulate past the care cart; no staff were observed in the vicinity.

In an interview with PSW #166 they stated to the Inspector that residents' prescription topical medications should have been covered with a sheet when on top of the care cart or stored in the bottom of the cart. They further stated that resident #001, who was, "all over the place" had probably uncovered the care cart, to expose the container. The PSW also verified that the care cart had been stored unsupervised leaving the prescription topical medications accessible to this particular resident. PSW #166 then verified (as they walked away leaving the container in place), that when not in use, the topical medications should have been

put at the nursing station.

PSW #160 then approached the Inspector and stated that they should have been returned the prescription topical medications to the RPN, and locked in the medication room. PSW #160 also stated that resident #001 was known to wander the unit, and the prescription topical medications should not have been left unattended when they were not in use.

In an interview, RPN #161 also verified to the Inspector that prescription topical medications were to be locked in the medication room when returned by the PSW.

On August 23, 2017, at 1102 hrs, in a specific home area, topical medications were again observed by the Inspector in an open clear plastic container, on an unattended care cart, stored in the corridor outside resident #001's room. A top sheet covered most of the cart; however, the container was exposed and its contents were visible. Within the plastic container, the Inspector found resident labelled prescription creams, lotions, and shampoo for three residents. The care cart was left unattended in the vicinity of resident #001's room, who was reportedly known to wander the home area.

In an interview with PSW #167 they stated to the Inspector that this container of prescription topical medications was not currently in use and should have been given to the RPN to be locked/secured.

PSW #168 verified to the Inspector that they were assigned to this section and although the prescription topical medications were to be locked by the RPN when not in use, on this day, they had forgotten.

On August 25, 2017, at 1105 hrs, in a specific home area, a clear plastic container with topical medications were observed by the Inspector, unsupervised on the counter of the nursing desk. Within the plastic container, the Inspector found resident labelled prescription creams, ointments, sprays, and shampoo for six residents. At this time, one ambulatory resident passed the container on the counter, where the Inspector observed it was within reach and view of the resident. Multiple residents were observed in the dining room, in close proximity to the container on the nursing desk.

Following the Inspector's observations, NP #134 and RN #169 both stated to the Inspector that prescription topical medications should not have been left on the

counter when unsupervised, and the NP stated it was a privacy issue. The RN then proceeded to remove the container from the counter and placed it in the nurse's office.

Further, on August 22, 2017, at 1345 hrs, the Inspector observed RPN #125 in a certain home area. The Inspector passed the dining room and observed an unattended medication cart stored against a half wall dividing the lounge and dining room at the junction of the two corridors leading to resident rooms. The Inspector observed the home’s electronic medication system MED e-care screen open with residents’ names and medications visible as a multitude of residents were observed in the immediate area. The drawers of the medication cart where resident’s medications were stored was unlocked.

The Inspector remained at the medication cart for five minutes until RPN #170 returned. Both RPN #170 and RPN #125 stated that the medication cart should have been locked when unsupervised. RPN #125 also stated that the MED e-care screen with resident names and medications should have been minimized when registered staff were away from the cart.

In an interview with CM #136 they confirmed to the Inspector that the medication cart should have been secured and locked when not supervised by registered staff.

2. On August 16, 2017, Inspector #620 observed that a medication cart adjacent to home’s dining room was left unlocked, unattended, and out of direct sight of RPN #113. The location where the cart was left unattended was a busy common area of the home and residents were noted to be in close proximity to the medication cart.

Inspector #620 waited in close proximity to the medication cart and upon RPN #113’s return to the medication cart, Inspector #620 asked the RPN what the home’s expectation was with regard to the safeguarding of medication. RPN #113 indicated that they only had to lock the cart when they were finished using it. The Inspector asked the RPN where the home’s medication storage policies could be located; they indicated that they did not know.

Inspector #620 reviewed the home’s policy titled, “Medication Policy and Procedure for Long-Term Care” with a revision date of January 2017. The document advised staff that the, “Medication cart is to be kept locked at all times unless in use and within sight.”

Inspector #620 interviewed Unit RN #111 who indicated that the medication cart was to be locked at all times when not in use and out of direct sight of the user.

Inspector #620 interviewed the Unit's Manager #111, and the home's DOC #114. Both confirmed that it was the home's policy that medication carts were to locked when not in use, or out of sight of the user. They indicated that RPN #113 had received training related the security of the drug supply, and should have known that the medication cart was required to be locked.

***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 stored in an area or a medication cart that is secured and locked, to be implemented voluntarily.***

---

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

While conducting an observation in a dining room on August 16, 2017. Inspector #620 observed that RPN #113 was conducting their noon medication pass. During the observation RPN #113 was observed to be preparing medications into medication cups and administering the medications to 11 residents. Residents were observed to be consuming the medication by putting the cups to their mouths and consuming the medication. Once consumed, RPN #113 was observed to be taking the empty medication cups with their bare hands to be disposed of in a trash container located at their medication cart. During the entire observation RPN #113 did not sanitize or wash their hands.

Inspector #620 reviewed a document titled, "Hand Hygiene- #IC 2-11" dated December 1, 2016. The document advised staff that hand hygiene was to be performed before and after the provision of direct care.

Inspector #620 interviewed RPN #113 about their knowledge of the home's infection prevention and control practices (IPAC). They indicated that they had received training in IPAC when they were first oriented to the home and on an ongoing basis. The Inspector advised RPN #113 that they had been observed to providing direct care to numerous residents without washing their hands. RPN #113 told the Inspector that they were only required to wash their hands before they began their medication pass. They indicated that if they went into a room under isolation then they were required to perform hand hygiene.

Inspector #620 interviewed RN #111 who indicated that RPN #113 was mistaken; staff were required to ensure that they performed hand hygiene any time they provided direct contact care with a resident. They stated that all staff received regular training related to the home's expectation on IPAC.

Inspector #620 interviewed Manager #136 and the DOC, both confirmed that when staff were providing direct resident care, they were expected to perform hand hygiene before and after the provision of care.

***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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

**Issued on this 27 day of December 2017 (A1)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et 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 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


## Amended Public Copy/Copie modifiée du public de permis

**Name of Inspector (ID #) / Nom de l'inspecteur (No) :** RYAN GOODMURPHY (638) - (A1)

**Inspection No. / No de l'inspection :** 2017_509617_0018 (A1)

**Appeal/Dir# / Appel/Dir#:**

**Log No. / No de registre :** 011881-17, 014564-17, 015832-17, 016286-17 (A1)

**Type of Inspection / Genre d'inspection:** Complaint

**Report Date(s) / Date(s) du Rapport :** Dec 27, 2017;(A1)

**Licensee / Titulaire de permis :**
ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251,
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 :** Judy Plummer

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

---

To ST. JOSEPH'S CARE GROUP, you are hereby required to comply with the following order(s) by the date(s) set out below:

---

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007, 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 is to ensure that the care set out in the plan of care is provided to:

1) Resident #028 regarding their activities of daily living care provision,
2) Resident #003 regarding their fall prevention interventions,
3) Resident #004 regarding their fall prevention interventions,
4) Resident #037 regarding their responsive behaviour interventions,
5) Resident #034 regarding their responsive behaviour interventions, and
6) to all other residents in accordance with their plan of care.

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #028 as specified in their plan.

Inspector #617 reviewed a complaint received by the Director regarding resident #028's care needs.

In an interview with the complainant they reported that on three separate occasions staff were not familiar with the care needs of resident #028, and did not provide the appropriate approach to assist the resident with their specific care needs. The complainant further explained that resident #028, if not approached in a consistent

manner as identified by their care plan, would refuse care.

A review of resident #028's Resident Assessment Instrument Minimal Data Set (RAI MDS), indicated that they were resistant to care, and required the assistance of staff for a number of specific interventions.

A review of resident #028's care plan, identified interventions for the provision of care and that staff were required to:
-introduce themselves each time they approached the resident,
-resident preferred care from specific staff members,
-resident would refuse when approached for personal care. Staff were instructed to use gentle persuasive approach for compliance and re-approach if necessary,
-complete night time care no earlier than 1900hrs,
-resident retired to bed around 1930-2000hrs, and
-remind the resident of meal times five minutes before it started.

On August 17, 2017, at 1618hrs, Inspector #617 observed resident #028 lying in their bed. Resident #028's family member was sitting at the bedside visiting. PSW #116, walked into the room, did not address the resident, proceeded to remove their covers and stated repeatedly, "time for pyjamas" to the resident and their family member. Resident #028's family member spoke to the PSW and said it was too early to put the resident into pyjamas and that it was too early to assist them to the dining room for their dinner, after which the staff member left the resident's room.

Then on August 17, 2017, at 1650hrs, Inspector #617 observed both PSW #157, and PSW #116 enter resident #028's room, and asked the resident if they wanted to come to the dining room for dinner. The resident responded with "no". The resident's family member asked the PSWs to come back in five minutes to assist the resident to the dining room.

A review of the dining schedule indicated that dinner was offered at 1700hrs.

Inspector #617 observed the August 17, 2017, dinner meal service, which identified that the first course of soup was offered at 1708hrs. The Inspector observed three PSWs working on the unit at the time and there were two female PSWs and one male PSW.

In an interview with PSW #116 both the Inspector and PSW #116 reviewed resident

#028's care plan regarding the resident's specific needs for personal hygiene. PSW #116 confirmed to the Inspector that they did not provide care to the resident as specified in their plan in relation to not identifying themselves when they walked into the room, and inappropriately offered night time care three hours too soon.

Inspector #617 interviewed PSW #157 who confirmed to the Inspector that they did not provide care as specified in their plan related to assisting resident #028 too soon to the dining room and the resident's preference to be cared for by specific staff members was not provided, triggering their refusal to receive care, and their resulting distress.

2. Inspector #616 observed resident #003 on August 16, 18 and 21, 2017, with a focus on falls prevention interventions and strategies, as they had sustained three falls with significant injury since their admission, with three falls requiring substantial medical intervention.

The Inspector reviewed the resident's current care plan where they were identified as at risk for falls related to the three falls causing the need for substantial medical intervention. The care plan identified interventions for falls prevention that included the use of a monitoring device and staff were to respond to resident #003's monitoring device immediately.

On two occasions (August 16 and 21, 2017) resident #003 was observed by the Inspector not having the monitoring device in place.

On August 21, 2017, the Inspector interviewed PSW #118 who reported that resident #003 was known to be at risk for falls. They stated that they were aware that the monitoring device was one of the interventions identified in their plan of care to prevent the resident from falling; however, they forgot to utilize the monitoring device that day.

On August 18, 2017, the Inspector observed resident #003, seated in their wheelchair in the corridor outside their room, when the monitoring device was activated. The Inspector noted that the device was activated for five minutes before PSW #119 was observed to walk at an unhurried pace toward the resident's room, at which time they deactivated the device.

During interviews with RPN #120 and PSW #119, they both reported that resident

#003 was known to be at risk for falls; both stated they were aware the resident's monitoring device had been activated on August 18, 2017. Both the RPN and PSW verified that it was the responsibility of all staff to respond immediately to the activation of resident #003's monitoring device.

RN #111 verified to the Inspector that on August 16, 2017, prior to lunch service, resident #003 did not have their monitoring device in place as required. They verified that the monitoring device was to be used at all times as a safety intervention listed in the resident's Kardex.

During an interview with CM #136, they stated that resident #003 was at risk for falls. They stated that is was the expectation of staff that they respond immediately to the activation of monitoring devices, and that the monitoring device was to be in place as per the care plan.

3. A Critical Incident report was received by the Director, concerning resident #004's fall, and resulting injury.

Inspector #577 reviewed resident #004's care plan, which instructed staff to ensure that the resident's call bell was within reach at all times and specific fall interventions were in place; staff were to ensure the resident's requirement for transfers, ensure all staff were informed, and make note at the bedside of the requirement.

During two observations on August 25, 2017, Inspector #577 observed the following:
-at 1115 hours, (hrs) the call bell in resident #004's room was lying on the floor, and the specific fall intervention was not initiated. Resident #004 was sitting on the side of their bed attempting to self-transfer. The Inspector noted a missing transfer logo at the bedside, and
-at 1325 hrs, resident #004 was lying in bed, their call bell was on the floor and the specific fall intervention was not initiated.

On that same day at 1340 hrs, CM #138 and the Inspector entered resident #004's room where they observed the call bell on the floor, the specific fall intervention was uninitiated, and the transfer logo was not present.

The CM confirmed with the Inspector that staff were not providing care as specified in the care plan.

4. The home submitted a Critical Incident report to the Director regarding resident-to-resident physical abuse. The CI report indicated that on a specific date, during the evening, RPN #130 witnessed a physical altercation between resident #037 and resident #040. The RPN separated the residents and discovered that resident #040 had been injured.

In an interview with RPN #130, they confirmed to Inspector #617 that they witnessed resident #040 and resident #037 engaged in a physical altercation on a specific day. The RPN reported that resident #040 was assessed to have sustained an injury.

In that interview, RPN #130 further explained to the Inspector that resident #037 required heightened observation in the form of increased monitoring, due to responsive behaviours.

A review of resident #037's RAI MDS, relevant to the time of the critical incident, indicated that they were assessed to have physically abusive and socially inappropriate behaviours, which were not easily altered.

A review of resident #037's care plan indicated that the resident had interventions for responsive behaviours.

A review of resident #037's physician's order indicated that the resident was to attend a specific program at the home and continue to have increased monitoring during specific times. This was due to the resident's responsive behaviour and risk to resident safety.

In an interview with RPN #130 they confirmed to the Inspector that at the time of the incident on a specific date resident #037 did not have the required increased monitoring. RPN #130 explained that resident #037 did not attend the specific program that day, and was on the unit the entire time.

In an interview with Staffing Coordinator #180, they confirmed to the Inspector that there were no staff scheduled for the increased monitoring of resident #037. The staffing clerk further explained that they were directed from the CM #138, that they were not required to provide the increased monitoring during certain times, as the resident was attending a specific program.

On a specific date, on four separate occasions, while the resident was to receive

increased monitoring, Inspector #617 observed resident #037 lying in bed sleeping in their room, and staff were not providing the increased monitoring.

In an interview with PSW #181, they reported to the Inspector that resident #037 was to attend a specific program on that day and was not feeling well. PSW #181 further explained that resident #037 had been awake and wandering most of the prior night and, as a result, was sleeping most of the day and had not gotten out of bed for breakfast or lunch.

In an interview with RT #182, they reported to the Inspector that resident #037 was to attend a specific program, seven days a week, and had not been in attendance over the last two weeks due to their illness.

In an interview with CM #138, they confirmed to the Inspector that resident #037 was required to attend a specific program and have increased monitoring during certain hours due to their responsive behaviours. CM #138 further confirmed that when resident #037 was not attending the specific program, they required increased monitoring when on the unit as per their plan of care. CM #138 explained that there had been a "disconnect" in communication. As a result, staff were unable to schedule and provide the care planned increased monitoring.

5. Inspector #617 reviewed a complaint received by the Director regarding staffing insufficiency in a specific home area, and the heightened monitoring of those residents with responsive behaviours.

In an interview with the complainant they reported to the Inspector that during an evening in a particular month, a specific unit was working short staffed and two residents, who were known to require increased monitoring due to their responsive behaviours, and the increased monitoring was not provided.

On August 18, 2017, Inspector #617 interviewed CM #165, who reported that for the entire particualr month on evening shifts, a specific home area required two PSWs to provide increased monitoring for both resident #034 and resident #032. CM #165 further explained that resident #034 required the increased monitoring to prevent a specific responsive behaviour.

A review of resident #034's RAI MDS, indicated that they were assessed as having responsive behaviours that were not easily altered. A review of the resident's care

plan indicated that they required increased monitoring.

A review of resident #034's physician's orders, indicated to continue increased monitoring for patient safety.

A record review of resident #034's progress notes dated for the particular month, indicated that during nine evenings, the resident exhibited responsive behaviours due to not having increased monitoring.

In an interview with PSW #183, they reported to the Inspector that during the particular month, resident #034 required increased monitoring, as required in their care plan, to prevent them from displaying persistent responsive behaviours. PSW #183 explained that when the increased monitoring was not available, because the unit was short staffed, the resident would display specific behaviours. PSW #183 further confirmed to the Inspector that there were occasions, during the particlar month when the unit was short staffed; as a result, increased monitoring was not provided to resident #034 as required in their care plan.

In an interview with PSW #184, they reported to the Inspector that resident #034 required increased monitoring during specific times in the particular month, due to their responsive behaviours. PSW #184 explained that when resident #034 was left alone, and did not have increased monitoring, they would exhibit certain responsive behaviours. PSW #184 confirmed that when the increased monitoring was not provided to resident #034, their care was not provided, as required in their care plan.

The decision to issue a Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, the severity was of potential harm to two residents that had fallen and two residents that had responsive behaviours, the scope of a pattern, was determined. The home has a history of non-compliance in this area of the legislation as follows:

- a CO during the Follow Up Inspection #2017_616542_0002 issued on March 7, 2017, and complied on April 18, 2017,
- a CO with a Director's Referral (DR) during the Follow Up Inspection #2016_391603_0024 issued on November 25, 2016, and complied on February 27, 2017,
- a CO during the Follow Up Inspection #2016_333577_0010 issued on July 13, 2016, and complied on November 7, 2017,

- a Voluntary Plan of Correction (VPC) during the Follow Up Inspection #2016_246196_0006 issued on March 29, 2016,
- a VPC during the Complaint Inspection #2016_246196_0005 issued on March 17, 2016,
- a CO during the Complaint Inspection #2016_264609_0006 issued on March 7, 2016, and complied on July 6, 2016,
- a Written Notice (WN) during the Resident Quality Inspection #2015_333577_0012 issued on June 15, 2015, and
- a VPC during the Resident Quality Inspection #2014_246196_0016 issued on September 2, 2014.

(617)

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

Feb 28, 2018(A1)

---

**Order # /**
**Ordre no :** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

**Order / Ordre :**

The licensee shall review, revise and implement their staffing plan to ensure that the plan promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident.

**Grounds / Motifs :**

1. 1. The home failed to ensure that their staffing plan promoted continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident.

Inspector #617 reviewed a complaint received by the Director regarding resident #028's continuity of care.

The Inspector interviewed the complainant who reported that on three separate occasions PSWs had asked them how to care for resident #028. On two separate occasions they had observed the resident had not been provided with proper care. The complainant voiced concern that the agency and new staff were not familiar with resident #028's care.

On two separate occasions during the inspection of the home, different resident

family members had approached the Inspector to voice their concerns about the continuity lacking from the PSW staff, as the agency PSWs and new staff hired over the summer were not familiar with the residents' care needs.

Inspector reviewed the home's staffing plan titled, "Staffing Plan for SJCG Long Term Care Homes Bethammi and Hogarth Riverview Manor" dated August 2017. The home's written plan did not identify the promotion of continuity of care by minimizing the number of different staff members, who provided nursing and personal support services to each resident.

The Inspector reviewed the home's "Staffing Guidelines for the RNs, RPN's and PSW's at Hogarth River Manor" dated July 2016, which identified that staffing levels were based on predetermined staffing ratios for direct-care, workload, work environment, resident complexity, skill level of the staff, staffing mix, and, the availability of support staff and other team members. The staffing office was to collaborate with the unit RN staff to adjust work assignments based on the predetermined ratios, and the availability of resources on any shifts. The document also indicated that, as employees of the Care Group any/all could be assigned to work in all areas of the homes as the need arose.

On a specific date Inspector #617 observed PSW #116 had started their evening shift in a specific home area at 1500hrs and was told by RN #126 that at 1800hrs they were to move to a different home area to complete their shift there, because the unit had been short staffed and required help.

Inspector interviewed PSW #116 who reported that they were an agency staff member and rotated on all the units. PSW #116 explained that they did not have a permanent rotation on a unit, and the maximum amount of shifts they work on the same unit was three consecutive shifts.

Inspector interviewed PSW #185 who reported that they had been hired in the past two months. PSW #185 explained that they had a designated unit; however, since their hire date, they had been scheduled on many different units, and worked no more than five consecutive shifts in a row on one unit.

In an interview with RN #143, they reported that due to staffing shortages, the registered staff had been required to move PSWs during a shift from one unit to another to help with PSW vacancies. As a result, residents had a number of PSWs

caring for them who may not have been familiar with their care.

In an interview with the DOC, they confirmed to the Inspector that the home's written staffing plan for the programs did not promote continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident. The DOC reviewed the legislation and confirmed that the home did not provide continuity to the residents.

The decision to issue a Compliance Order was based on the home's ongoing non-compliance unrelated to this section of the legislation, the severity was of potential harm to residents that had staff unfamiliar to their care needs, the scope of a pattern, was determined. (617)

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

Feb 28, 2018(A1)

## 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 Health and 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

## 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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

## 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

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)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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  27  day of December 2017 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** RYAN GOODMURPHY - (A1)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

## Order(s) of the Inspector

## Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

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