Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
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130, avenue Dufferin 4ème étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2021	2021_533115_0005	009937-21, 010368-21, 010521-21, 010822-21	Complaint

Licensee/Titulaire de permis

Richmond Terrace Limited
284 Central Avenue London ON N6B 2C8

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

Richmond Terrace
89 Rankin Avenue Amherstburg ON N9V 1E7

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

TERRI DALY (115), CASSANDRA TAYLOR (725)

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 14 & 15, 18 - 22, 2021.

The following complaint intakes were completed within this inspection:
Log #009937-21, Log #010368-21, Log #010822-21 related to personal support services and insufficient staffing,
Log #010521-21 related to responsive behaviours and insufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Vice President of Best Practices and Innovation, the Director of Programs and Support Services, the Director of Clinical Services, Registered Nurses (RN), Registered Practical Nurses, (RPN), Personal Support Workers (PSW), a housekeeping aide and residents.

During the course of the inspection the inspector(s) observed and reviewed the home's Infection Prevention and Control (IPAC) practices, conducted observations, reviewed relevant internal documentation and resident clinical records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Recreation and Social Activities
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with 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 residents were bathed, at a minimum, twice a week by the method of their choice.

Multiple complaints were received through the Ministry of Health and Long-Term Care infoline (IL) related to missed baths due to insufficient staffing.

During a record review of resident's bathing schedules and Point of Care (POC) documentation for scheduled bathing and as needed (PRN) bathing it was noted that several resident's records included staff documentation of NA – Not Applicable.

Interviews with a Personal Support Worker indicated that the documentation in POC NA – Not Applicable, would mean that the bath was not completed. A PSW when asked if resident baths had ever been missed on a specific unit, responded "yes".

Five residents were identified as having missed baths during a specific time period.

During an interview with a resident about staffing and the home working short, the resident was asked if they ever miss their bath, the resident indicated they had missed baths.

A review of the home's Resident Council meeting minutes from a specific date, under agenda item 7. Comments/Concerns indicated that:
"Council feels that the insufficient staffing is affecting their quality and consistency of care. They would like to know what Richmond Terrace is doing to recruit new staff and what Richmond Terrace is doing to retain current staff."
"They are concerned with the lack of bathing opportunities. Comments were made that they could go 7 days with no bath and the majority stated that they only get one bath a week."

During an interview with the ED, it was indicated that when a resident misses a bath there is an extra shift that is scheduled to complete baths. The ED confirmed that the baths should have been completed.

Not ensuring residents receive the minimum required baths per week places residents at increased risk for unkept hygiene and concerns about dignity.

Sources: five resident's records, Resident Council meeting minutes, resident and staff interviews. [s. 33. (1)]

Additional Required Actions:

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

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care provided clear direction to staff.

On review of the residents care plan it was noted that the resident was to be checked or changed at specific times. When looking at the online charting system for the Personal Support Workers (PSW), Point of Care (POC) the only toileting information was to complete changes or checks every shift or when required.

During staff interviews with a PSW and the Director of Clinical Services (DCS) it was indicated that the care plan and kardex should match.

Not providing clear direction to staff could have placed the resident at risk for missed care opportunities.

Sources: Resident records; Care plan and Kardex, and staff interviews with a PSW and the DCS. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plans of care provide clear direction to staff, to be implemented voluntarily.

WN #3: 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. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times.

On review of the registered staff schedule from a specific time period, the inspector observed a date where there was no designated responsible Registered Practical Nurse (RPN) for the allowable exception of the Registered Nurse (RN) hours. Other RPNs were in the building however none were designated as the charge nurse covering the RN shift during that time.

Review of the documentation with the Executive Director (ED) they agreed the RN hours on that date, should have had a designated charge RPN if an RN was unavailable.

Not ensuring that RN hours were covered during that time placed residents at risk as there was no designated registered staff in charge.

Sources: Registered staff schedule and staff interview with the ED. [s. 8. (3)]

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 at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff is on duty and present at all times, to be implemented voluntarily.

Issued on this 24th day of November, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TERRI DALY (115), CASSANDRA TAYLOR (725)
Inspection No. / No de l'inspection :	2021_533115_0005
Log No. / No de registre :	009937-21, 010368-21, 010521-21, 010822-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 23, 2021
Licensee / Titulaire de permis :	Richmond Terrace Limited 284 Central Avenue, London, ON, N6B-2C8
LTC Home / Foyer de SLD :	Richmond Terrace 89 Rankin Avenue, Amherstburg, ON, N9V-1E7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Annette Morris

To Richmond Terrace Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with section 33 of Ontario Regulation 79/10.
Specifically, the licensee must:
-ensure that resident #003, #006, #007, #009, #010, and any other resident receives a bath, at minimum twice a week, by method of their choice.
-Complete weekly audits of resident bathing that was and was not completed. The audits will be of one resident home area a week and the resident home area will rotate. Audits will be completed for a minimum of three months or until the order is complied.
-Keep a written record of the weekly bathing audit and include the resident, the person completing the audit, the outcome of the audit and corrective action if necessary.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of their choice.

Multiple complaints were received through the Ministry of Health and Long-Term Care infoline (IL) related to missed baths due to insufficient staffing.

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A review of the home's Resident Council meeting minutes from a specific date, under agenda item 7. Comments/Concerns indicated that:
"Council feels that the insufficient staffing is affecting their quality and consistency of care. They would like to know what Richmond Terrace is doing to recruit new staff and what Richmond Terrace is doing to retain current staff."
"They are concerned with the lack of bathing opportunities. Comments were made that they could go 7 days with no bath and the majority stated that they only get one bath a week."

During an interview with the ED, it was indicated that when a resident misses a bath there is an extra shift that is scheduled to complete baths. The ED confirmed that the baths should have been completed.

Not ensuring residents receive the minimum required baths per week places residents at increased risk for unkept hygiene and concerns about dignity.

Sources: five resident's records, Resident Council meeting minutes, resident and staff interviews. [s. 33. (1)]

An order was issued after taking the following factors into account:
Severity: Five out of five residents reviewed were not receiving their baths twice per week. This resulted in minimal harm to the residents.

Scope: This issue was widespread since all five residents were not receiving baths, at a minimum, twice per week.

Compliance History: In the last 36 months, the licensee was found to be non complaint with O.Reg. 79/10 s.33 and a voluntary plan of correction was issued to the home. (115)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 17, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 23rd day of November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TERRI DALY

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