Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 18, 2018	2018_740621_0014	012856-17, 004484-18, 007816-18, 008120-18, 008124-18, 008131-18, 008197-18, 008207-18, 008215-18, 008293-18, 009172-18	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

JULIE KUORIKOSKI (621), LAUREN TENHUNEN (196)

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): May 1-4, 7-10, 2018.

The following intakes were inspected during this Complaint Inspection:
Five intakes related to nursing and personal support services;
One intake related to nursing and personal support services, and wound management;
One intake related to nursing and personal support services, and responsive behaviour management;
One intake related to nursing and personal support services, and infection control;
One intake related to nursing and personal support services, and plan of care;
One intake related to nursing and personal support services, and restraints; and
One intake related to alleged staff to resident abuse.

A Resident Quality Inspection #2018_633577_0006 was conducted concurrently with this Complaint Inspection.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Director of Care (DOC), Acting Director of Care (ADOC), Clinical Manager(s), Infection Prevention and Control Facilitator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Staffing Coordinator, Dietary Aides, Housekeeping Aides, residents and family members.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident, and resident to resident interactions, reviewed relevant health records, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

4 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint was received by the Director related to the provision of personal care and staffing in the home.

On a day in May 2018, a complainant reported to Inspector #196 that a specific resident unit was working short with a specified number of PSWs during a particular shift.

During an interview with RPN #127, they confirmed the staffing ratio on the unit for a specific time period, on the same day, to Inspector #196. RPN #127 also reported to the Inspector that because a specific number of PSWs on that shift were familiar with the residents, they had been able to complete the residents' care. Further, RPN #196 indicated that the PSWs would have let them know if there had been any concerns with completing the residents' care.

During an interview with PSW #126, they reported to Inspector #196 that all care, with exception of a certain type of care for a specific resident, had been completed.

On another day in May 2018, documentation which tracked a certain type of resident care was reviewed by Inspector #196. The Inspector identified during the review that there was no documentation for resident's #018, #019 and #020 to indicate a specific care activity had been completed during a specific shift, on a specified day, in May 2018.

During an interview with RPN #127 on the same day in May 2018, they reviewed the electronic health record with Inspector #196 and confirmed there was no documentation

of a specific care activity being completed for the identified residents.

During an interview with resident #019 and #020, they confirmed to Inspector #196 that a specific care activity had been completed for them during a specific shift, on a specified day, in May 2018.

During an interview with Clinical Manager #113, they reported to Inspector #196 that the PSWs were to record and document the care provided in the electronic health record. Clinical Manager #113 reviewed a specific section of the electronic health record and confirmed to the Inspector that a particular care activity for resident's #018, #019 and #020 had not been documented on a specific shift on a specified day in May 2018, and they expected that if a bath was done, it would be recorded as done. [s. 6. (9) 1.]

2. A complaint was received by the Director related to staffing concerns.

On a day in May 2018, a complainant reported to Inspector #621 that a particular resident unit was working short with a specific number of PSWs on a specified shift on a day in April 2018, and that a PSW had informed the complainant that they had only been able to complete a particular care activity for a certain number of residents during that shift.

During an interview, on a day in May 2018, PSW #120 confirmed to Inspector #621 that they had worked on a particular unit, for a specific shift, on a day in April 2018. PSW #120 identified that documentation for a specific care activity had not been completed due to the workload and shortage of PSWs on that shift.

Inspector #621 reviewed records for a specific care activity and identified that there was no documentation for residents #010, #011 and #012 to indicate the missed care during on that shift in April 2018.

During an interview with RPN #104 on another day in May 2018, they reported to Inspector #621 that PSW staff were to complete a specific care activity as identified in the residents’ plan of care, and document by end of shift that care was provided in the electronic health record. RPN #104 further identified that if a specific care activity was missed, that PSWs were to inform the RPN on duty, and document this also in a specific location of the electronic health record.

RPN #104 reviewed a specific care activity schedule with Inspector #621, along with

corresponding documentation in the electronic health record for a specific day in April 2018, for resident's #010, #011 and #012. RPN #104 confirmed that each of the identified residents were scheduled to have a specific care activity completed on a certain shift on that day, and confirmed that there was no care documentation on the electronic health record for that shift. [s. 6. (9) 1.]

3. A complaint was submitted to the Director, which identified that a specific time on a specific day in April 2018, the complainant visited resident #005 to find a specific number of PSWs on duty to care for a specified number of residents on that unit, and that PSW staff were unable to attend to all of the residents’ care needs.

During an interview on a day in May 2018, PSW #101 reported to Inspector #621 that on a particular shift on a specific day in April 2018, they and PSW #124 were unable to complete a specific care activity for residents #013, #014, #015 and #016. Additionally, PSW #101 confirmed to the Inspector that documentation had not been completed by the PSWs during that shift with regards to resident #013, #014, #015 and #016’s missed care.

Inspector #621 reviewed specific health records for resident's #013, #014, #015 and #016. The Inspector identified that there was no documentation to indicate whether a specific care activity was provided or not during the identified shift in April 2018, for the same four residents.

During interviews with Interim Clinical Manager #110 they reported to Inspector #621 that it was their expectation that PSWs document missed care in a specified location of the electronic health record. Interim Clinical Manager #110 reviewed resident #013, #014, #015, and #016’s care activity schedule, and confirmed that all four residents had been scheduled to have a specific care activity completed on a particular shift in April 2018, and verified that there was missed care documentation on the electronic health record for that shift. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the provision of care set out in the plan of care is documented, 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 licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

A complaint was submitted to the Director, which identified that on a day in April 2018, the complainant visited resident #005 to find a specific number of PSWs on duty to care for a specified number of residents, and that staff were unable to attend to all the

residents' care needs. Additionally, the complainant reported that they contacted the manager on duty, but that the manager had no answers to remedy the situation, and admitted that they were on another home area assisting with resident care themselves.

During an interview on a day in May 2018, PSW #101 confirmed to Inspector #621 that they worked a particular shift on a specific day in April 2018, for a specified resident unit. PSW #101 reported that along with RPN #100, they and PSW #124 were the only staff who worked that particular shift, and were responsible for the care of a specified number of residents, with a specific number which required a certain type of care. PSW #101 identified that the home was short PSWs throughout the entire home that day, with their unit short one regular PSW and one float PSW for that particular shift. PSW #101 identified that as a consequence, they were unable to complete a certain care activity for residents #013, #014, #015 and #016. PSW #101 further identified that when a certain care activity could not be completed, PSWs were responsible to complete documentation on each respective residents' electronic health record to indicate that the care activity was not completed, as well as document on a specific form the missed care. PSW #101 confirmed to the Inspector that due to insufficient staffing on that unit, documentation had not been completed during that shift with regards to resident #013, #014, #015 and #016's missed care.

During an interview, RPN #100 reported to Inspector #621 that on a specific shift, for a particular unit, on a day in April 2018, they were the RPN on duty. RPN #100 identified to the Inspector that PSWs #101 and #124 notified them that they were unable to complete specific care for that shift; confirmed that a specific form had not been completed by the PSWs to document the missed care, and that they had not notified the Clinical Manager that day of the missed care and missed documentation for the four residents. Additionally, RPN #100 confirmed that they had worked that particular shift with less than full complement of PSW staff.

During a review of the home's staffing replacement guidelines titled "Hogarth Riverview Manor Shift Replacement Guidelines", last updated February 13, 2018, it identified that PSW staffing targets for a specified unit included: three PSWs for an eight hour shift from 0700 to 1500 hrs, and one PSW from 0700 to 1100 hrs. Additionally, it identified that when a unit worked with less than full complement, or was "Short", and a scheduled care activity was missed, a certain type of report was to be completed, and the most responsible registered staff (RN or RPN) was to communicate a plan for rescheduling the missed care with staff on the next shift, and the appropriate Manager.

During an interview with Interim Clinical Manager #110 on two days in May 2018, they reported to Inspector #621 that the home had a PSW staffing issue and that when home areas were running short, that completion of a specific type of care activity and respective documentation were the first things to not get completed. Interim Clinical Manager #110 confirmed that a specific type of report had not been completed for a day in April 2018, to identify the missed care for residents #013, #014, #015 and #016. On review a specific care activity schedule for resident #013, #014, #015, Interim Clinical Manager #110 confirmed that all four residents were scheduled as per their plan of care to have a specific care activity completed on a certain day in April 2018, and verified that there was missed care documentation on the electronic health record for each of the four residents on that shift. Additionally, Interim Clinical Manager #110 confirmed that documentation provided no indication that the care activity was made up as expected.

During an interview with Clinical Manager #109 on a specific day in May 2018, they confirmed to Inspector #621 that they had been the Clinical Manager that was on-call for a specific day in April 2018, and that they had received a call from a resident's family member with regards to concerns that a specific resident unit was working short PSWs at a particular time of day. Clinical Manager #109 reported to the Inspector that they informed the family member that they were aware; that there were staffing issues throughout the entire home that day; and that the home's staffing plan had been activated, but that there had been no call-backs to fill the vacancies. Additionally, Clinical Manager #109 reported that they recommended to the family member, that since this was a staffing issue, they should also follow up their concerns with Family Council and the Director of Care (DOC). Further, Clinical Manager #109 identified that as a result of not being able to fill the PSW vacancies that day, they themselves were on-site and assisting to provide direct resident care on a specified unit. Finally, Clinical Manager #109 indicated that in hind sight, they should have contacted the DOC themselves to troubleshoot the home's staffing issues that day, but did not. [s. 31. (3) (a)]

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 staffing plan provides 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was 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.

A complaint was submitted to the Director on April 20, 2018, which indicated that resident #004 did not receive a bath on a day in March 2018, due to short staffing on the unit.

The bath schedule from a particular resident unit identified that resident #004 was to have a bath on two particular days each week. The staff schedule for the specific unit, on a specified day in March 2018, as provided by Staffing Coordinator #118, identified that the unit was working with a particular number of RPN and PSW staff.

The "Hogarth Riverview Manor Shift Replacement Guidelines", dated February 13, 2018, was provided by the Interim Administrator on May 3, 2018, as the written staffing plan for the home. Within this plan, under the title of 'When the Unit/Section is at less than full complement "Short"', the direction read: "If there is a circumstance a scheduled

bath/tub/shower is missed there is a need to complete a bed bath. Complete the Bath report *attached and communicate the plan for rescheduling the bath in shift to shift report with team members".

During an interview on a day in May 2018, Clinical Manager #113 was unable to provide a "Bath Report" for the specific day in March 2018. Clinical Manager #113 confirmed to the Inspector, after a review of the bath schedule and electronic health record, that resident #004 had not had a bath on a specific day in March 2018. In addition, further documentation did not indicate that a bath was provided the following shift or the following day. They added that it would be expected that if a bath was provided, it would be documented. [s. 33. (1)]

2. A complaint was submitted to the Director, which indicated that on a day in April 2018, the complainant visited a particular unit at a certain time to find a specific number of PSW staff on duty to care for a specified number of residents, and that staff were unable to attend to all the residents' care needs.

During an interview on a day in May 2018, PSW #101 confirmed to Inspector #621 that they worked a certain shift on a day in April 2018, for a particular resident unit. PSW #101 reported that they and PSW #124 were the only PSWs on duty for the identified shift, and as a consequence were unable to complete scheduled twice weekly baths for resident's #013, #014, #015 and #016. PSW #101 further identified that when a scheduled bath could not be not completed, PSWs were responsible to complete documentation in a particular section of the electronic health record, to indicate that the scheduled bath was not completed, as well as document the missed bath on the home's "Bath Report" form. PSW #101 confirmed to the Inspector that documentation had not been completed on a particular day and shift in April 2018, with regards to the resident #013, #014, #015 and #016's missed bath care.

During an interview on a day in May 2018, RPN #100 reported to Inspector #621 that on a specific day and shift for a particular unit in April 2018, PSWs #101 and #124 notified them that they were unable to complete the scheduled baths for that shift.

Inspector #621 reviewed resident #013, #014, #015 and #016's health care record. The bathing schedule indicated that all identified residents were to receive their scheduled baths on two particular dates. The plan of care for each resident identified that that they preferred a specific type of bath care. The electronic health record for each of the four residents was absent documentation for the a particular shift in April 2018; there was no

indication the bath was rescheduled and completed on the next shift; and each of the four residents only received one bath during the week.

During an interview with Interim Clinical Manager #110 on two dates in May 2018, they reported to Inspector #621 that it was their expectation that PSWs report to the RPN any missed bath care on their shift, and document the missed care on the electronic health record. Further, Interim Clinical Manager #110 identified that the RPN on duty was expected to notify staff coming onto the next shift about incomplete baths. On review of resident #013, #014, #015, and #016's bath schedule, Interim Clinical Manager #110 confirmed that all four residents were scheduled to have bath care completed on a specific day and shift in April 2018; confirmed that there was missed bath documentation for that shift; that the scheduled baths were not made up on the next shift, the next day, or until each resident's next scheduled bath. Consequently, Interim Clinical Manager #110 verified that as a result of the missed baths, resident #013, #014, #015 and #016 had not received a minimum of two baths weekly according to their assessed needs and preferences. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

A complaint was received by the Director regarding resident care and staffing concerns.

On a specific day in May 2018, a complainant reported to Inspector #196 that a particular resident unit was working short with only a certain number of PSWs on a specified shift.

During an interview, RPN #127 confirmed the staffing ratio on the unit during that shift and identified that the PSWs would have let them know if there had been any concerns with providing care.

At a specified time, Inspector #196 asked RPN #127 whether between-meal beverages had been offered to the residents at a particular time of the day on that unit, to which the RPN reported that they were not aware.

During an interview, PSW #126 reported to Inspector #196 that a particular beverage service for residents had not been completed as a result of being short staffed.

During an interview with Clinical Manager #113, they reported to Inspector #196 that they had been made aware that a particular between-meal beverage service had not been provided to the residents and that the staff should have called for assistance. [s. 71. (3) (b)]

Issued on this 23rd day of May, 2018

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

Original report signed by the inspector.