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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 25, 2015	2015_256517_0013	002087-15, 002590-15	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE MUNICIPALITY OF CHATHAM-KENT
519 King Street West CHATHAM ON N7M 1G8

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

RIVERVIEW GARDENS
519 KING STREET WEST CHATHAM ON N7M 1G8

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

PATRICIA VENTURA (517)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 6, 2015

Log#002590-15/M626-000005-15 and Log#002087-15/M626-000003-15 were completed to determine if the home is in compliance with legislation in regards to alleged abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Director of Care, three Nurse Managers, one Registered Practical Nurse and three Personal Support Workers.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensured that the Resident's Substitute Decision Maker (SDM) and any other person specified by the Resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Health record review and staff interviews revealed a Manager became aware of an incident of alleged, suspected or witnessed abuse involving Resident #2. The Manager initiated an internal investigation and submitted a Critical Incident Report to the Director under the category of Abuse/Neglect. Interview with the Manager revealed that upon completion of the internal investigation the home found no abuse had taken place. The home also found that one staff member violated the rights of Resident #2. The Substitute Decision Maker of Resident #2 was not notified of the alleged abuse or the results of the internal investigation.

The home's policy titled "Resident Protection (Res)" last revised in July of 2014 indicated: "The RN in charge will immediately notify the resident's SDM upon becoming aware of alleged, suspected or witnessed incident of abuse that has resulted in physical injury or pain to the resident or that caused distress to the resident that could affect the resident's health or well-being and will notify the SDM within 12 hours of becoming aware of any other alleged, suspected or witnessed abuse or neglect of the resident."

Interview with the Director of Care confirmed the home's expectation that the Substitute Decision Maker be notified within 12 hours of the licensee becoming aware of alleged, suspected or witnessed incident of abuse that has not resulted in physical injury or pain to the resident or that did not cause distress to the resident that could affect the resident's health or well-being as per the home's Resident Protection (Res) policy. [s. 97. (1) (b)]

Issued on this 3rd day of June, 2015

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

Original report signed by the inspector.