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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 20, 2015	2015_206115_0028	027266-15	Resident Quality Inspection

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

TERRI DALY (115), CAROLEE MILLINER (144), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 5, 6, 7, 8, 9, & 13, 2015

During the course of the inspection, the inspector(s) spoke with the Director of Senior Services, the Director of Nursing, the Social Worker, the Activation Supervisor, a Food Services Coordinator, a Nurse Manager, six Registered Nurses, twelve Registered Practical Nurses, nine Personal Support Workers, the Family Council President, four family members and forty one residents.

The Inspector(s) toured all resident home areas, observed dining services, medication storage rooms, medication administration, the provision of resident care, recreational activities, staff/resident interactions, infection and prevention control practices and reviewed resident clinical records, posting of required information, meeting minutes related to the inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

3 WN(s)
2 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. 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident had the right to participate fully in making any decision concerning any aspect of care, including any decision concerning transfer to a secure unit and to obtain an independent opinion with regard to any of these matters.

The Substitute Decision Maker (SDM) for a resident indicated that the home advised that the resident was being transferred to another home area.

A review of the resident's clinical record revealed that staff had not documented that the SDM had been notified of the resident's status and the plan to transfer the resident to another home area.

During the telephone interview the SDM revealed that the home had not been provided the opportunity to discuss the decision related to the internal transfer, and stated "it was clear the decision had already been made".

The Director of Nursing (DON) confirmed the expectation that the SDM should have been notified of the resident's status, and a documented discussion should have occurred prior to the transfer of the resident which included reasons for the transfer. [s. 3. (1) 11. iii.]

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 have the right to participate fully in making decisions concerning any aspect of his or her care, including any decision concerning his or her transfer to a secure unit and to obtain an independent opinion with regard to any of these matters, to be implemented voluntarily.

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. (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 resident 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.

The Substitute Decision Maker (SDM) for a resident stated that the home advised by telephone that the resident was being transferred to a different Resident Home Area (RHA) due to care requirements.

Review of the resident's clinical record confirmed that the resident had exhibited a change in care.

The plan of care had not been reviewed and revised to include changes in care.

The Registered Nurse (RN) and the Director of Nursing (DON) confirmed the plan of care should have been reviewed and revised to include all changes in care. [s. 6. (10) (b)]

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 are 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was:
b)complied with.

A resident had an area of altered skin integrity. The resident had an order that indicated that the area was to be assessed and documented in Point Click Care (PCC) weekly.

The home's policy, Wound Care, revised October 2015 indicated the following:
"Registered staff will:
With a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds will:
a)Conduct a skin assessment, weekly and sign on Treatment Administration Record (TAR) and document finding in PCC in skin and wound assessment."

Review of the clinical record indicated that a weekly wound assessment was completed and signed on the TAR as required on 19 occasions. Review of the PCC notes indicated that there was missing documentation in PCC notes on 7 of 19 occasions (37%).

A Registered Nurse confirmed that the clinical record for this resident was missing the required documentation in PCC per the homes policy. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 20th day of October, 2015

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

Original report signed by the inspector.