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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 24, 2016	2016_257518_0045	027450-16	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

ALISON FALKINGHAM (518), TERRI DALY (115)

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): September 28, 2016 October 3, 4, 5, 6, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, one Nurse Manager, three Registered Nurses(RN), eight Registered Practical Nurses(RPN), six Personal Support Workers(PSW), one Occupational Therapist(OT), one Physiotherapist(PT), one Recreational/Restorative Aid, and two housekeepers. The inspectors also conducted a tour of the nursing home, observed general infection control practices and a medication administration, spoke with three resident family members and observed general staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an assessment of the resident's needs had been completed.

A resident was observed using a medical device on two occasions.

The plan of care indicated the use for this medical device.

PSW #106 confirmed that the resident required this medical device.

There was no documentation related to an assessment for the use of the medical device or interventions while the medical device was in use.

The home's policy and procedure Medical Care revised July 13, 2016 Use of A PASD indicated:
The assessment will:
1. Identify precipitating factors for considering a Personal Assistive Service Device (PASD) including the clinical indicator(s) of functional deficits.

The DOC #101 explained that the home had not completed an assessment that included factors for considering the use of a PASD including clinical indicators of functional deficits and that no care was set out in the plan of care related to the use of a medical device as a Personal Assistive Service Device(PASD). [s. 6. (2)]

2. The licensee has failed to ensure that an assessment of the resident's needs had been completed.

A resident was observed using a medical device on two occasions.

The plan of care indicated the use for this medical device.

PSW #121 confirmed that the resident required this medical device.

There was no documentation related to an assessment for the use of the medical device or interventions while the medical device was in use.

RPN #117 was unsure who would complete an assessment for the use of this type of device.

The home's policy and procedure Medical Care revised July 13, 2016 Use of a PASD indicated:

The assessment will:
1. Identify precipitating factors for considering a PASD including the clinical indicator(s) of functional deficits.

The DOC #101 explained that the home had not completed an assessment that included factors for considering the use of a PASD including clinical indicators of functional deficits and that no care was set out in the plan of care related to the use of a mechanical device as a Personal Assistive Service Device(PASD). [s. 6. (2)]

3. The licensee has failed to ensure that an assessment of the resident's needs had been completed.

A resident was observed using a medical device on three occasions.

The plan of care indicated the use of this medical device.

RPN #118, PSW #120 and Physiotherapist #119 confirmed that the resident required the medical device.

There was no documentation related to an assessment for the use of the medical device or interventions while the medical device was in use.

The home's policy and procedure Medical Care revised July 13, 2016 Use of PASD indicated:
The assessment will:
1. Identify precipitating factors for considering a PASD including the clinical indicator(s) of functional deficits.

DOC #101 explained that the home had not completed an assessment that included factors for considering the use of a PASD including clinical indicators of functional deficits and that no care was set out in the plan of care related to the use of a medical device as a Personal Assistive Service Device(PASD).

The licensee failed to ensure that an assessment was completed for three residents which included factors for consideration the use of a PASD including clinical indicators of functional deficits and no care was set out in the plan of care related to the resident's use of a medical device as a PASD. [s. 6. (2)]

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A resident was observed to be incontinent of urine, with a strong odour and wetness noted on their clothing.

A review of the Minimum Data Set(MDS) and the most recent Resident Assessment Protocols(RAP) revealed that the resident had experienced bladder continence worsening and was now totally incontinent of bladder function.
The MDS coding showed gradual decline in bladder function from admission until

present.

A review of the clinical record found that a bladder incontinence assessment that included causal factors, patterns, type of incontinence and the potential to restore function was not completed during this time.

During an interview with Nurse Manager #116 and Director of Nursing #101 it was stated that the home had not been completing continence care assessments, and that the home's policy needed to be revised to reflect the need for assessment when there has been a change in the resident's condition that may affect bladder or bowel continence or a significant change in continence status. [s. 51. (2) (a)]

2. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Review of a resident clinical record revealed that the Minimum Data Set(MDS) and the Resident Assessment Protocol(RAP) indicated total incontinence of bowel and bladder. The MDS coding showed a gradual decline in bowel and bladder function.

A review of the clinical record found that a continence assessment that included causal factors, patterns, type of incontinence and the potential to restore function was not completed during this time.

During interviews with the Nurse Manger #116, Director of Nursing #101 and RN #103 it was stated that the home had not been completing continence assessments, and that the home's policy needed to be revised to reflect the need for assessment when there has been a change in the resident's condition that may affect bladder or bowel incontinence or a significant change in the continence status. [s. 51. (2) (a)]

3. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or

circumstances of the resident require.

A resident was frequently incontinent according to the most recent Minimum Data Set (MDS) assessment.

On admission an initial bladder/bowel continence assessment was completed indicating that the resident was continent of bladder function, each MDS assessment completed from there after indicated that the resident was frequently incontinent of bladder function.

A review of the clinical record found that a bladder incontinence assessment that included causal factors, patterns, type of incontinence and the potential to restore function was not completed during this time.

During an interview with Nurse Manager #116 and Director of Nursing #101 it was stated that the home had not been completing continence care assessments, and that the home's policy needs to be revised to reflect the need for assessment when there has been a change in the resident's condition that may affect bladder or bowel continence or a significant change in continence status. [s. 51. (2) (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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinent and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

Issued on this 1st day of November, 2016

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

Original report signed by the inspector.