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
Jun 13, 2018	2018_532590_0004	003936-18	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

ALICIA MARLATT (590), ANDREA DIMENNA (669), DEBRA CHURCHER (670), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 23, 26, 28, March 1, 2, 5, 6, 7 and 8, 2018.

The following intakes were inspected concurrently within this RQI:

Complaint inspection: Log #013040-17/IL-51497-LO was related to resident rights;
Complaint inspection: Log #021441-17/IL-52791-LO was related to prevention of abuse and neglect;

Complaint inspection: Log #029321-17/IL-54671-LO and IL-54743-LO was related to falls prevention and management and medication management;
Critical Incident System (CIS) inspection: Log #011256-17/CIS #M626-000026-17 was related to responsive behaviours;
CIS inspection: Log #012186-17/CIS #M626-000028-17 was related to falls prevention and management;
CIS inspection: Log #014878-17/CIS #M626-000033-17 was related to prevention of abuse and neglect;
CIS inspection: Log #018869-17/CIS #M626-000037-17 was related to to prevention of abuse and neglect;
CIS inspection: Log #020418-17/CIS #M626-000039-17 was related to medication management;
CIS inspection: Log #020950-17/CIS #M626-000040-17 was related to falls prevention and management;
CIS inspection: Log #025070-17/CIS #M626-000046-17 was related to falls prevention and management;
CIS inspection: Log #028409-17/CIS #M626-000051-17 was related to medication management;
CIS inspection: Log #029126-17/CIS #M626-000053-17 was related to falls prevention and management;
CIS inspection: Log #000709-18/CIS #M626-000001-18 was related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Director of Senior Services, the Director of Nursing (DON), two Nurse Managers (NM), the Environmental Supervisor, a Registered Dietitian (RD), a Social Worker, a Housekeeper, a Resident Assessment Instrument Nurse, four Registered Nurses (RN), 25 Registered Practical Nurses (RPN), 23 Personal Care Providers (PCP), a representative of the Residents' Council, a representative of the Family Council, four family members and 13 residents.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, Infoline reports, Critical Incident System reports, Family Council meeting minutes, Residents' Council meeting minutes, email correspondence, incident reports, investigation reports, Falls Prevention/Restraint Reduction Committee meeting minutes, Professional Advisory Committee meeting minutes and policies and procedures relevant to inspection topics.

During the course of the inspection, the inspector(s) observed dining and snack services, recreational activities, infection prevention and control practices, the provision of resident care, staff and resident interactions, medication administration practices, medication storage areas, all resident home areas, the general maintenance and cleanliness of the home, fire safety drills and the posting of required information.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 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	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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff recorded symptoms of infection in residents on every shift.

During stage one of the Resident Quality Inspection (RQI), resident #005 was identified for having an infection from the most recent Minimum Data Set (MDS) assessment.

RPN #112 and #119 were interviewed, and stated when a resident was found to be symptomatic for any type of infection, the resident would be placed on a line listing, and that the resident would be monitored and the assessment of symptoms would be documented as a progress note in PCC on every shift until the symptoms ceased.

RN #113 was interviewed, and stated that when an unregulated staff member suspected a resident was ill, they would report to the RPN, who would then report to the RN. RN #113 stated that the resident's name, symptoms and the date of onset would be recorded on the home's line listing form. RN #113 then stated that the resident would be monitored, and the assessment of symptoms would be recorded on each shift as a progress note in PCC.

The progress notes were reviewed from the noted onset of symptoms, to the noted cessation of symptoms for resident #005. The progress notes showed that on a specified date, resident #005 exhibited symptoms, and was placed on the outbreak line listing. On a later specific date, resident #005 was observed with no further symptoms. There were no documented assessment of symptoms for: three day shifts in 2018, the evening shifts on four occasions in 2018, and the night shift on another specified date in 2018.

NM #118 was interviewed and stated that registered staff were responsible to record the name, date of onset and the symptoms of any resident who presented with any infectious symptoms. NM #118 stated that registered staff were then responsible to assess the resident and record the assessment and symptoms in PCC until the symptoms resolved. The NM reviewed resident #005's progress notes and stated that the assessment of symptoms for resident #005 had not been recorded on every shift until they were resolved.

DON #101 stated in an interview that registered staff members were to document in PCC on every shift from onset to cessation of any infectious symptoms for any resident. [s. 229. (5) (b)]

2. During stage one of the RQI, resident #003 was identified for having an infection from the most recent MDS assessment.

Review of the home's Outbreak Line Listing for a specific month in 2017, showed that resident #003 was added to the line listing on a specific date, due to specific symptoms. The Outbreak Line Listing listed the symptoms as resolved on a later specified date.

Review of resident #003's progress notes starting on a specific date, showed that the resident was initially showing symptoms on the night shift on a specific date. Inspector #670 was unable to locate any recording of symptom monitoring for: the night shifts on four occasions in 2017, the day shifts on five occasions in 2017, and the evening shifts on three occasions in 2017.

In an interview NM #118 stated that any resident that was symptomatic related to an infectious process should have their symptoms monitored every shift and this would be documented in the resident’s progress notes. NM #118 stated that they believed the staff had monitored resident #003’s symptoms but had not recorded them in the progress notes and should have.

DON #101 stated that any resident with an infection was to have their symptoms monitored and documented in the progress notes every shift until the symptoms resolved. [s. 229. (5) (b)]

3. During stage one of the RQI, resident #001 was identified for having an infection from the most recent MDS assessment.

Review of the resident #001's progress notes showed that the resident was noted to be symptomatic with infectious symptoms on the evening shift on a specific date, with symptoms resolving on a later specific date in 2017. Inspector #670 was unable to locate any symptom monitoring documentation for: the night shifts on 13 occasions in a specific month in 2017 and 23 occasions in the subsequent month in 2017, the day shifts in a specific month on 10 occasions and 15 occasions in the subsequent month in 2017, and the evening shifts in a specific month on 15 occasions and 17 occasions in the subsequent month in 2017.

In an interview NM #118 stated that any resident that was symptomatic related to an infectious process should have their symptoms monitored every shift and this would be documented in the resident’s progress notes. NM #118 stated that they believed the staff had monitored resident #001’s symptoms but had not recorded them in the progress notes and should have.

In an interview DON #101 stated that any resident with an infection was to have their symptoms monitored and documented in the progress notes every shift until the symptoms had resolved.

The licensee has failed to ensure that on every shift, symptoms of infection in resident #005, 003 and 001 were recorded. [s. 229. (5) (b)]

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. (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 the care set out in the plan of care was documented.

During stage one of the RQI, resident #006 was identified for having weight loss from a chart review.

The written plan of care for resident #006 included direction for staff when the resident refused food, or intake was less than 50 percent.

Review of resident #006's food and fluid intake records in Point Of Care (POC) for a 14 day time period in 2018, showed that resident #006's provision of care was not documented.

In an interviews with RPN #138 and Registered Dietitian (RD) #149, they both stated that the provision of care for resident #006 should have been documented and recorded

in POC.

The licensee has failed to ensure that the provision of care set out in the plan of care for resident #006 was documented. [s. 6. (9) 1.]

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

During stage one of the RQI, resident #012 was identified for having weight loss from a chart review.

Resident #012 was assessed as a high nutritional risk on admission in a specified month in 2017, and again three months later.

Review of resident #012's care plan, showed that there were directions for staff when the resident refused food and that staff were to document the amount of foods and fluids taken.

Review of resident #012's food and fluid intake records in POC for a 14 day time period in 2018, showed that the provision of care was not documented consistently.

In interviews with RPN #138, 117 and RD #149, they all stated that the provision of care for resident #012 should have been documented and recorded in POC. RPN #117 stated that the provision of care had not been documented for resident #012.

The licensee has failed to ensure that the provision of care set out in the plan of care for resident #012 was documented. [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 the care set out in the plan of care is documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month.

During stage one of the RQI, resident #016 was identified for having weight loss from a chart review.

Review of resident #016's assessments showed that the last completed nutritional assessment, was this resident's annual assessment which was documented on a specified date. The resident was classified as a moderate nutritional risk at that time. There were no documented referrals to the RD.

Review of resident #016's progress notes for a 44 day time period, showed that the RD had not documented anything about this resident for their weight loss.

The home's policy Therapeutic Nutritional Care - Weight and Height Monitoring, policy code DIET THE, last revised in October 2017, stated in the procedure section that: "Registered Nursing Staff are to determine if there has been a 5% or greater weight change in one month. The following steps are required if a 5% or great weight change is identified.
a. The resident is to be –reweighed by nursing on their next bath day.
b. The reweigh weight is recorded by nursing in the resident's weights/vitals section in

PCC and the original weight is removed.
c. If a 5% of greater weight change is confirmed by the re-weigh, the RN completes a Dietary Requisition and sends it to the Registered Dietitian for assessment. Nursing staff are to indicate the % of weight change, the weight for the previous month, the current month and the reweight weight on the requisition form in pointclickcare (PCC)."

In an interview with RPN #117, they shared that weights were completed by the PCP's and the RD would communicate any need for a re-weigh to staff.

In an interview with RPN #107, they shared that within the first week of each month the PCP's were to weigh the residents and document their weights in POC. They said that registered staff were to be monitoring the recorded weights at the end of the first week each month and were to re-weigh any residents that had a five percent or greater change in their weights. The new weight would be entered into PCC and if there was a true weight change, a referral to the RD would be completed by registered staff in PCC. The referral form described the reason for referral so the RD can determine if they need to see the resident for weight loss or gain purposes.

In an interview with RD #149, they shared that they were not aware of resident #016's weight loss. They shared that a referral had not been sent to them regarding this resident's weight loss. The RD said that when staff observed weight loss in residents they were to be making referrals to the RD for assessment in PCC. The RD said that this resident has experienced a weight loss of greater than 5 percent in a one month period and should have been made aware of this resident's weight loss and was not.

The licensee has failed to ensure that resident #016's weight loss was assessed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 with significant weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Review of the home's medication incident reports for July, August and September of 2017, showed a medication incident on a specific date in 2017. The medication incident report stated that RPN #132 had administered a narcotic medication to resident #013 when the resident should have been administered a different narcotic.

The home's policy Medical Care-Medications, last revised December 12, 2017, stated: "Medications can only be administered subsequently to a written or verbal phone order by the attending physician, dentist, medical director, and/or nurse practitioner."

Review of resident #013's medication orders showed that resident #013 did not have the administered narcotic ordered.

An interview was conducted with NM #118 who acknowledged that resident #013 received a medication that was not ordered for them.

An interview was conducted with DON #101 who stated that the resident had received a medication that was not ordered for them and should not have received the administered narcotic.

The licensee has failed to ensure that no drug was used by or administered to a resident

in the home unless the drug had been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Review of the home's medication incident reports for July, August and September of 2017, showed two medication incidents on two different specified dates, one related to an incorrect dose of a narcotic and the other was related to a missing dose of an antibiotic.

The home's policy Medical Care-Medications, last revised December 12, 2017, stated: "Nurses have a responsibility to administer every drug precisely as it is ordered."

One medication incident on a specified date, stated that RPN #133 administered 1 mg of a narcotic to resident #015 when the resident should have had 0.5 mg administered.

Review of resident #015's medication orders showed an order for the administered narcotic, 0.5 mg by mouth.

An interview was conducted with NM #118 who acknowledged that resident #015 received a double dose of narcotic and the medication was not administered as prescribed.

The other medication incident on a specified date, stated that RPN #134 signed for, but did not administer, resident #014's antibiotic.

Review of resident #014's medication orders showed an order for the antibiotic.

An interview was conducted with NM #120 who acknowledged that the resident was not administered the ordered medication as per the physicians order.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate actions were taken in response to a medication incident involving a resident.

Review of the home's medication incident reports for July, August and September of 2017, showed two medication incidents, each on a different day. One medication incident was related to the incorrect medication being administered and the other incident was related to an incorrect dose of a narcotic.

The home's policy Medication Incidents, last revised June 23, 2014, stated: "Immediate actions are taken to assess and maintain the resident's health."

The medication incident report on a specified date, stated that RPN #132 had administered a narcotic to resident #013 when the resident should have been administered a different narcotic.

Review of resident #013's medication orders showed that resident #013 did not have the administered narcotic ordered.

The second medication incident on a specified date, stated that RPN #133 administered 1 mg of narcotic to resident #015 when the resident should have had 0.5 mg administered.

Review of resident #015's medication orders showed an order for the narcotic, 0.5 mg by mouth.

Inspector #670 was unable to locate any documentation regarding assessments or follow-up related to the medication incidents for either resident.

The NM #118 was unable to locate any documentation or follow-up for resident #013 and #015 and stated that based on the risk of these medication incidents the home would expect that there would be regular monitoring of each resident's respiratory and neurological status, and vital signs. NM #118 stated that if the monitoring and assessments had been completed they would have been documented in Point Click Care (PCC) and if there was no documentation, the residents were not assessed nor monitored.

In an interview with DON #101, they stated that it was the expectation of the home that in the event of a medication incident, that registered staff would monitor and assess the resident for any adverse effects and that the assessments and monitoring would be documented in PCC.

The licensee has failed to ensure that appropriate actions were taken in response to a medication incident involving a resident. [s. 134. (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 appropriate actions were taken in response to a medication incident involving a resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident.

A Critical Incident System (CIS) report #M626-000046-17, was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date in 2017, and described that resident #020 had two falls and sustained an injury. This CIS was inspected during the home's RQI.

The CIS report stated that on a specific date in 2017, resident #020 was guided to the floor by staff. The report continued that later the same day, resident #020 was self-transferring and fell.

DON #101 and NM #118 were interviewed and reviewed the CIS report and stated that resident #020 had experienced a significant change in status after the falls.

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident. [s. 107. (3) 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was reported to the physician and the resident's substitute decision maker (SDM).

Review of the home's medication incident reports for July, August and September of 2017, showed a medication incident on a specified date, related to a missing dose of an antibiotic.

The medication incident report stated that RPN #134 signed for, but did not administer resident #014's antibiotic.

Review of resident #014's medication orders showed an order for the missed antibiotic.

The home's policy titled Medication Incidents, last revised June 23, 2014, stated: "The physician is to be informed of medication incidents that involve the resident as per facility policy. The error or adverse drug reaction is also to be reported to the resident and/or substitute decision maker."

Inspector #670 was unable to locate any documentation regarding notification of the physician or the SDM of the medication error.

In an interview, NM #120 was also unable to locate any documentation that the physician and SDM was notified of the medication error. The NM stated that if there was no documentation on the medication incident, that the physician and SDM were not notified.

In an interview with DON #101, they stated that it was the expectation of the home that medication errors that reached the resident would be reported to the physician and the SDM.

The licensee has failed to ensure that every medication incident involving a resident was reported to the physician and the resident's substitute decision maker. [s. 135. (1)]

Issued on this 14th day of June, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALICIA MARLATT (590), ANDREA DIMENNA (669), DEBRA CHURCHER (670), NANCY SINCLAIR (537)
Inspection No. / No de l'inspection :	2018_532590_0004
Log No. / No de registre :	003936-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 13, 2018
Licensee / Titulaire de permis :	The Corporation of the Municipality of Chatham-Kent 519 King Street West, CHATHAM, ON, N7M-1G8
LTC Home / Foyer de SLD :	Riverview Gardens 519 King Street West, CHATHAM, ON, N7M-1G8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tami Gillier

To The Corporation of the Municipality of Chatham-Kent, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with r. 229. (5) of the Regulations.

Specifically the licensee must ensure that staff record symptoms of infection in residents on every shift.

Grounds / Motifs :

1. The licensee has failed to ensure that staff recorded symptoms of infection in residents on every shift.

During stage one of the RQI, resident #001 was identified for having an infection from the most recent MDS assessment.

Review of the resident #001's progress notes showed that the resident was noted to be symptomatic with infectious symptoms on the evening shift on a specific date, with symptoms resolving on a later specific date in 2017. Inspector #670 was unable to locate any symptom monitoring documentation for: the night shifts on 13 occasions in a specific month in 2017 and 23 occasions in the subsequent month in 2017, the day shifts in a specific month on 10 occasions and 15 occasions in the subsequent month in 2017, and the evening shifts in a specific month on 15 occasions and 17 occasions in the subsequent month in 2017.

In an interview NM #118 stated that any resident that was symptomatic related to an infectious process should have their symptoms monitored every shift and

this would be documented in the resident's progress notes. NM #118 stated that they believed the staff had monitored resident #001's symptoms but had not recorded them in the progress notes and should have.

In an interview DON #101 stated that any resident with an infection was to have their symptoms monitored and documented in the progress notes every shift until the symptoms had resolved.

(670)

2. During stage one of the RQI, resident #003 was identified for having an infection from the most recent MDS assessment.

Review of the home's Outbreak Line Listing for a specific month in 2017, showed that resident #003 was added to the line listing on a specific date, due to specific symptoms. The Outbreak Line Listing listed the symptoms as resolved on a later specified date.

Review of resident #003's progress notes starting on a specific date, showed that the resident was initially showing symptoms on the night shift on a specific date. Inspector #670 was unable to locate any recording of symptom monitoring for: the night shifts on four occasions in 2017, the day shifts on five occasions in 2017, and the evening shifts on three occasions in 2017.

In an interview NM #118 stated that any resident that was symptomatic related to an infectious process should have their symptoms monitored every shift and this would be documented in the resident's progress notes. NM #118 stated that they believed the staff had monitored resident #003's symptoms but had not recorded them in the progress notes and should have.

DON #101 stated that any resident with an infection was to have their symptoms monitored and documented in the progress notes every shift until the symptoms resolved.
(670)

3. During stage one of the Resident Quality Inspection (RQI), resident #005 was

identified for having an infection from the most recent Minimum Data Set (MDS) assessment.

RPN #112 and #119 were interviewed, and stated when a resident was found to be symptomatic for any type of infection, the resident would be placed on a line listing, and that the resident would be monitored and the assessment of symptoms would be documented as a progress note in PCC on every shift until the symptoms ceased.

RN #113 was interviewed, and stated that when an unregulated staff member suspected a resident was ill, they would report to the RPN, who would then report to the RN. RN #113 stated that the resident's name, symptoms and the date of onset would be recorded on the home's line listing form. RN #113 then stated that the resident would be monitored, and the assessment of symptoms would be recorded on each shift as a progress note in PCC.

The progress notes were reviewed from the noted onset of symptoms, to the noted cessation of symptoms for resident #005. The progress notes showed that on a specified date, resident #005 exhibited symptoms, and was placed on the outbreak line listing. On a later specific date, resident #005 was observed with no further symptoms. There were no documented assessment of symptoms for: three day shifts in 2018, the evening shifts on four occasions in 2018, and the night shift on another specified date in 2018.

NM #118 was interviewed and stated that registered staff were responsible to record the name, date of onset and the symptoms of any resident who presented with any infectious symptoms. NM #118 stated that registered staff were then responsible to assess the resident and record the assessment and symptoms in PCC until the symptoms resolved. The NM reviewed resident #005's progress notes and stated that the assessment of symptoms for resident #005 had not been recorded on every shift until they were resolved.

DON #101 stated in an interview that registered staff members were to document in PCC on every shift from onset to cessation of any infectious symptoms for any resident.

The licensee has failed to ensure that on every shift, symptoms of infection in resident #005, 003 and 001 were recorded.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope was determined to be a level 3 as it related to three of three residents reviewed. The home had a level 4 compliance history as they had on-going non-compliance with this section of the Regulations that included:

- A Voluntary Plan of Correction (VPC) issued May 1, 2017 (2017_563670_0001). (537)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2018

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 13th day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Alicia Marlatt

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