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
Mar 6, 2018	2018_678680_0003 (A1)	004779-17, 025134-17, 029225-17, 029237-17	Complaint

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

TRACY RICHARDSON (680) – (A1)

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): February 13, 14 and 16, 2018

Complaint Log #029237-17, IL-54661-L0 regarding alleged abuse, concerns regarding continence care and activities of daily living
The following Critical Incident Intakes were inspected:
Log # 029225-17, Critical Incident Report # M626-000054-17
Log # 025134-17, Critical Incident Report # M626-000047-17
Log # 004779-17, Critical Incident Report # M626-000008-17

During the course of the inspection, the inspector(s) spoke with the Director of Care, two Nurse Managers, the Medical Director, the Physiotherapist, Physiotherapy Assistant, Registered Practical Nurses, Registered Nurses, Personal Support Workers, residents, and family members.
The inspector(s) also made observations of residents, and activities and care of residents. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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. 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise have in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

Ontario Regulation 79/10, r. 114. (2) The licensee shall ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Ontario Regulation 79/10, r. 114. (3) The written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

In an interview the family member of a specific resident stated that the resident kept medications in their room and administers them themselves.

Observation in the resident room showed that there were medications in the room. The resident was not present in the room. The nurse manager acknowledged that the pills were not secured and was not sure what the pills were in the containers and removed them from the room.

Review of the policy titled "Medical Care- Self-Administered Medications," dated December 12, 2017, stated, "self-administration of medications by a Resident is permitted when specifically ordered by a physician, who determines that the Resident is capable of self-administering his/her own medications and they have a clear understanding of the use and need for medications. These medications are stored in a secure area, inaccessible to other Residents."

The Nurse Manager removed the medications from the room and acknowledged that the medications were not secure and were accessible to residents who wander.

The licensee has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise have in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with. [s. 8. (1) (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 the written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

O. Reg. 79/10, s. 2 (1).Verbal abuse" means,
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or
(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. ("mauvais traitement d'ordre verbal")

Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding alleged staff to resident abuse involving a specified resident.

The CIS related to allegations that a registered practical nurse (RPN) had made a derogatory response to a resident. The incident had been witnessed on a specific date by Personal Support Workers (PSW) and reported to management on a different date.

In an interview a registered staff member stated that resident had made the comment to them. The registered staff member shared that they had made a sarcastic response back to the resident. The registered staff member stated that they did not recall using a swear word when speaking to the resident. The registered staff member shared that they did not mean it the way it was said and that they had been accused of verbal abuse but that it was not true at all. The registered staff member shared that the follow up training that they were supposed to have had not occurred as of yet.

Review of the policy titled "Resident Protection (RES)- Resident Abuse," dated Revised

July 2014, it stated:
"emotional abuse of a resident means:
-stress or distress caused by abuse
-verbal abuse, including, but not limited to:
swearing
name-calling
threats or insults
shouting belitting
-threatening or insulting gestures, behaviour, or language
-imposed social isolation including shunning, ignoring or lack of acknowledgement
-any treatment or behaviour that may diminish the sense of identity, dignity, and self-worth"

Review of a letter to the registered staff member it stated that the registered staff member had received mandatory training, which reviewed the Home's mission statement and the Residents' Bill of Rights. The letter stated that "all employees are expected to treat residents with dignity and respect and are to be cared for in a manner consistent with their needs. As a result of the above violation, your language and response to the resident is a violation of our policy on resident abuse."

Review of the investigation records showed that two Personal Support Workers (PSW's) had written statements that they had witnessed the registered staff member using a swear word in their response to the resident.

In an interview the Director of Care (DOC) they stated that registered staff member had not received training and they would follow up on this.

The licensee has failed to ensure that residents were protected from abuse by anyone. [s. 19. (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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Review of the policy titled "Resident Protection (RES)- Resident Abuse," revised date July 2014
The Home's Employees and Volunteers shall:
-comply with this policy and shall ensure that others comply with and are aware of this policy
-report immediately to the Director, of Nursing (or designate) any alleged, suspected or witnessed incident of abuse/neglect of a resident.
All staff must

2. Immediately report* any incident of witnessed or alleged Resident abuse to the Director of Nursing or in their absence: the Director, Seniors Services OR the RN in charge OR the Nurse Manager."

Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding alleged staff to resident abuse.

The CIS related to allegations that a registered practical nurse (RPN) had made a derogatory response to a resident which involved swearing. The incident had been witnessed on by Personal Support Workers (PSW) and reported to management on a specific date.

The DOC acknowledged that the incident had occurred prior to the date reported to the Director notification. [s. 20. (1)]

2. Review of the policy titled "Resident Protection (RES)-Resident Abuse," dated July 2014 stated the following: "The Director of Nursing (or designate) will ensure all incidents are alleged, suspected, or witnessed abuse are reported immediately as per the Critical Incident Reporting/Mandatory Reporting to the Director, Ministry of Health-Long Term care -section 24."

A) Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding allegations staff to resident abuse. The CIS stated the incident occurred on a specific date and time.

Review of the CIS is stated that the family member of the resident witnessed a Personal Support Worker (PSW) do physical and forceful care on the resident on a specific date and time.

In a review of the chart for the resident, on the specified date and time a registered staff member was asked to speak to the family regarding an incident. The note stated that "incident report, vitals and head to toe completed and pain mapping initiated. The note also stated that the Nurse Manager (MN) and the Director of Care (DOC) had been notified.

In an interview the Nurse Manager (NM) stated that the allegation was made by a family member. The NM stated that the staff did not initiate the CIS and did not call the after hours line to report the incident and that the report should have been completed immediately.

B) Review of the policy titled "Resident Protection (RES)-Resident Abuse," dated July 2014 stated the following: "The Director of Nursing (or designate) will ensure all incidents are alleged, suspected, or witnessed abuse are reported immediately as per the Critical Incident Reporting/Mandatory Reporting to the Director, Ministry of Health-Long Term

care -section 24."

Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding alleged staff to resident abuse that occurred on a specific date and time. The CIS stated that the after hours emergency contact had not been notified.

The CIS alleged that a staff member had spoken to a resident in a derogatory manner and the family member had reported this incident to a registered staff member that day. The CIS stated that family had stated "this is abuse" and critical incident (CI) "initiated and investigation completed."

In an interview the Director of Care (DOC) stated the investigation was completed the same day that the incident occurred on and that the CIS was not submitted on time and that it was an oversight.

The licensee has failed to ensure that the policy that promoted zero tolerance of abuse and neglect of residents was complied with. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the screening measures included criminal reference checks.

Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding alleged staff to resident abuse.

Review of the CIS stated that the family member of the resident witnessed a Personal Support Worker (PSW) do physical and forceful care on a specific resident.

In an interview the Director of Care (DOC) shared that staff member alleged to have been abusive was hired on a specific date, and that there was no police check on file for this staff member. The DOC shared that human resources was unable to locate the police record. The DOC shared that it might have been destroyed.

The licensee has failed to ensure that the screening measures included criminal reference checks were conducted prior to hiring the staff member. [s. 75. (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 screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers. The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (4) The licensee shall enter into the appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3). O. Reg. 79/10, s. 82 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that they entered into the appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3).

A complaint was submitted to the Ministry of Health and Long-Term Care, related to a resident wanting to keep their own physician and not the home's physician.

In an interview with the resident and their family member, they stated that they were going to their own physician. The POA stated that the resident's personal physician had refused to sign the contract with the home but had agreed to continue to care for the resident.

Review of a letter that was sent from the Administrator to the attending resident's personal physician asking for them to sign a contract, the doctor faxed back stating that they would not sign the agreement with the home.

Interview with the Director of Care (DOC) they stated that they did try to obtain a contract with the resident's personal physician but that they had been unsuccessful in doing this.

In an interview the Medical Director (MD) stated that they were prepared to co-sign orders with the resident's personal physician. The MD stated that they did not have permission from the family to see the resident and that they were monitoring them. The MD stated that the family had an outside physician for years and that this had just become an issue recently.

The licensee has failed to ensure that they entered into the appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3). [s. 82. (4)]

Issued on this 28th day of February, 2019 (A1)

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

Original report signed by the inspector.