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 prévue 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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 20, 2019	2018_532590_0024 (A1)	006112-18, 007677-18, 007813-18, 013543-18, 025956-18	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

Amended by ALICIA MARLATT (590) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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Areas of legislation changed due to error

Issued on this 20th day of February, 2019 (A1)

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

Inspection Report under *the Long-Term Care Homes Act, 2007*

Ministère de la Santé et des Soins de longue durée

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

Amended by ALICIA MARLATT (590) - (A1)

Amended 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): November 13 - 16, 19 - 23, 26 and 27, 2018.

A follow up inspection was completed within this complaint inspection, Log #013543-18.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Administrator, the Director of Nursing, the Manager of Resident Services, five Nurse Managers, one Registered Dietitian, one Activation staff member, three Registered Nurses, five Registered Practical Nurses, seven Personal Support Workers, three family members and several residents.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, the homes' internal investigation notes, Critical Incident System reports, Infoline reports, incident reports, staff education records, employee records, email correspondence and policies and procedures relevant to inspection topics.

During the course of the inspection, the inspector(s) observed mechanical lift transfers, staff and resident interactions, recreational activities, infection prevention and control practices and the posting of the homes' complaint process.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (5)	CO #001	2018_532590_0004	590

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours included:
• assessment
• reassessments
• interventions, and
• documentation of the resident's responses to the interventions.

A complaint letter was submitted to the Ministry of Health and Long Term-Care (MOHLTC) related to an alleged incident of abuse between resident #002 and #003.

In a pre-inspection interview with the complainant, they shared with the inspector that they had met with staff at the home and they had requested and insisted that the home work to keep resident #002 and #003 separated for safety reasons.

Review of resident #003's progress notes showed that the resident was witnessed by staff to be interacting with resident #002 on three separate occasions within a month time period.

A review of internal investigation notes showed that a meeting occurred with the homes management team and the family of resident #002. The notes documented that the family had requested that the two residents be kept separated and requested that resident #003 be transferred, but that the home was not able or willing to accommodate the request. The family requested that if the two residents were seen together, they were to be separated and distracted by staff immediately.

Review of both residents' care plans showed interventions that were in place to assist the staff in managing the behaviours of both of the residents, however neither care plan identified that resident #003 had previous interactions with resident #002, nor did it document that the residents should be kept separate. Hourly safety checks on the residents had been initiated.

Review of resident #003 and #002's clinical records, along with internal incident reports, showed that there was some missing documentation. An incident report was not completed after one of the incidents. After the last incident, resident #003 did not have an aggressive resident checklist completed and resident #002 did not have a head to toe assessment completed.

Review of the homes' policy titled 'Medical Care – Responsive Behaviour', last revised on December 12, 2017, showed that direction was provided to staff that "Any incidents of responsive behaviours will be documented in the progress notes and the physician and SDM will be informed of the incident. Registered staff will complete an aggressive resident checklist.".

In an interview with Registered Practical Nurse (RPN) #113, they said that when an incident happened between two residents, an incident report was to be completed, along with a head to toe assessment. RPN #113 stated that an incident report had not been completed for the first incident. This RPN also stated that a head to toe assessment had not been completed for resident #002 after the incident.

In an interview with Nurse Manager (NM) #106 they agreed that there was no assessment completed for resident #002 after the last incident and a head to toe assessment should have been completed. The NM also agreed that the aggressive resident checklist was not completed for resident #003 after the incident and should have been.

In an interview with NM #102 they shared that after the first incident they initiated safety checks of the residents, so resident #003 was not near resident #002.

In an interview with NM #106, they shared that they had advocated for a room transfer after the first incident, and shared that they felt the two residents should be kept separated and communicated this concern to their superiors, however it was not their decision to determine appropriate room arrangements. NM #106 agreed that the care plan in place did not specifically address the situation of these two identified residents.

The licensee had failed to ensure that the actions taken to meet the needs of resident #003 included assessment, reassessments, interventions and documentation of the resident's responses to the interventions. [s. 53. (4) (c)]

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 actions taken to meet the needs of the resident with responsive behaviours include:
• assessment
• reassessments
• interventions, and
• documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

(A1)
1. The licensee had failed to ensure that the persons who had received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Long-Term Care Homes Act, 2007, s. 76. (2) documents that every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Ontario Regulation 79/10 r. 218. documents that for the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided: 2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Ontario Regulation 79/10 r. 219. (1) The intervals for the purposes of subsection 76. (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Long-Term Care Homes Act, 2007, s. 76. (1) documents that every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c.8, s. 76 (1).

A letter of complaint was received by the MOHLTC which identified concerns related to staff education. The letter specified that the lack of education concern was related to the staff who used the mechanical lifts in the home.

In interviews with Personal Support Worker's (PSW) #103, 104, 111 and 112, they all shared that mechanical lift training was completed during orientation, however was not completed annually thereafter. All the PSW's mentioned having the resource available of a 'lift team', who were identified workers in the home that had received training by the mechanical lift providers representative and who also complete the orientation for new staff and students who would be using the lifts. The PSW's identified that refresher in-services were held twice a year during the spring and fall, and they usually covered some type of lifting education. When asked to clarify if they reviewed each type of mechanical lift and their proper use every year, each PSW said they did not review each machine every year.

In an interview with Manager of Resident Services #101, they shared that mechanical lift training did not occur in 2017, but all staff were trained in 2016. When asked if the mechanical lift training occurred every year they shared that it did not occur every year.

Review of the homes mechanical lift training records for 2016 and 2017, showed that all staff were trained on how to properly use the mechanical lifts in 2016, however there were no documents to review for the 2017 year.

In an interview with the Director of Nursing (DON) #105, they shared that mechanical lift training did not occur every year. On orientation all staff were required to complete the mechanical lift training, for all lift types used in the home. Refreshers were provided to staff each spring and fall, on some type of lift technique and there was also a lift team that had been established in the home. The lift team members have been trained by the representative of the mechanical lift provider, to act as a resource for other staff members who may have questions

about the use of the lifts in between refreshers.

The licensee had failed to ensure that all staff were trained annually for the use of the mechanical lifts. [s. 76. (4)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Ontario Regulation 79/10, s. 101. (1) documents that every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member

concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. 2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

A complaint letter was submitted to the MOHLTC related to an alleged incident of abuse between resident #003 and resident #002.

During a telephone interview the complainant stated that they felt their concerns about resident #003 interacting with resident #002 were not appropriately dealt with by the management of the home.

A review of the home's policy code: ADM RES "Resident Protection (RES) Complaint Procedure" last revised in July 2014, stated in part "All complaints will be taken seriously and will be fully investigated" and "If a complaint cannot be investigated and resolved within ten (10) business days, the supervisor will provide an acknowledgement of receipt of the complaint within ten (10) business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that provides the following information will be provided as soon as possible: a. What was done to resolve the complaint, or b. That the home believes the complaint to be unfounded and the reasons for this belief".

A review of the resident's clinical records showed that the home knew about the family's concerns on a specified date.

A review of the home's incident file regarding the complainant's concerns only included the home's interviews with the family.

On November 14, 2018, the inspector requested the documented records required by the Regulation and DON #105 could not provide them by November 16, 2018.

On November 15, 2018, and dated that day, DON #105 provided the Inspector a summary of the incidents that occurred between resident #002 and resident #003 and the actions taken.

The licensee had failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant. [s. 101. (2)]

Issued on this 20th day of February, 2019 (A1)

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

Original report signed by the inspector.