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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 12, 2019	2019_791739_0005	028386-18, 031069-18, 032696-18, 033173-18, 000624-19, 001629-19, 002295-19	Critical Incident System

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

JULIE DALESSANDRO (739), CASSANDRA TAYLOR (725), SAMANTHA PERRY (740)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 4, 5, 6, 7, and 8, 2019.

The following intakes were completed in this Critical Incident System Inspection:
Related to falls:
Log #032696-18 / IL-62657-AH / CI #M626-000072-18
Log #033173-18 / CI #M626-000073-18
Log #028386-18 / IL-61161-AH / CI #M626-000050-18

Related to improper care:
Log #031069-18 / CI #M626-000063-18

Related to responsive behaviours:
Log #001629-19 / IL-63619-AH / CI #M626-000004-19
Log #002295-19 / IL-63815-AH / CI #M626-000006-19
Log #000624-19 / IL-63229-AH / CI #M626-000003-19

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Behaviour Support Ontario Personal Support Worker (BSO/PSW), Registered Practical Nurses (RPN), Behaviour Support Ontario Registered Practical Nurse (BSO/RPN), Registered Nurses, and Nurse Managers.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, pertaining to resident #004. The CIS report indicated that resident #004 had a fall resulting in injury.

During record review for resident #004 in Point Click Care (PCC) progress notes it indicated that the resident had several falls between specific dates, and resident #004 exhibited injury. The Medical Doctor (MD) was notified on a specific date regarding the increase in falls with no orders received. On a different date, the resident began to show signs of increased pain and was rigid in body position. MD was notified and ordered resident #004 be sent to the hospital and have a medical examination completed. Progress notes indicated that on a specific date at an approximate time, the hospital phoned and stated that resident #004 had a medical examination completed with no significant findings and would return to the home.

During record review for resident #004 in PCC progress notes it indicated that resident #004 continued to have injury to their leg accompanied by another type of injury. Staff notified the MD on a specific date, and received an order to transfer resident to the hospital for further assessment. Hospital staff phoned on a specific date to indicate a medical examination was completed with no injury noted but other possible medical complications were noted. Hospital requested resident to return on another date, for further testing. On a specific date, resident #004 returned from hospital to the home with family and a diagnosis of injury and no other complication. During record review in PCC assessments resident was noted to be a moderate risk for falls.

During record review of resident #004's plan of care, falls interventions were documented to assist with prevention of falls. Resident #004 was to have fall prevention strategies in place.

During an interview with Registered Practical Nurse (RPN) #108 and Nurse Manager #104 both indicated that resident #004 was to have specific fall prevention strategies in place as part of the falls prevention plan of care.

During an observation on a specific date, Inspector #725 observed resident #004's room

and was unable to locate fall prevention equipment. Inspector #725 asked PSW #106 to accompany them to the room. When in resident #004's room Inspector #725 asked if resident #004 was to have fall prevention equipment, PSW #106 replied yes. Inspector #725 asked where the fall prevention equipment was and PSW #106 indicated that that a specific piece of fall prevention equipment was not in the room. Upon exiting the room resident #004 walked past wearing one slipper and one plain stocking foot. PSW #106 was asked if resident was dressed according to current interventions and PSW #106 replied no but resident did take shoes off.

During a record review of the falls interventions there was no documentation to support that resident #004 removed shoes.

During a record review of the homes nursing policies and procedure Policy: Medical Care – Fall Prevention, Policy Code: NUR MED last revised: December 12, 2017, stated under Personal Support Workers (PSW): "1. Follow the interventions as outlines on the care plan".

During an interview with Nurse Manager #104, inspector #725 informed them of the observation findings and asked what the expectation would be for fall prevention interventions. Nurse Manager and Falls Team Chair #104 indicated that it would be the expectation that interventions were in place as per the care plan.

The licensee has failed to ensure that the care set out in the plan of care for resident #004 was provided to the resident as specified in the plan. [s. 6. (7)]

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 care specified in the plan of care is provided to the resident, to be implemented voluntarily.

Issued on this 12th day of March, 2019

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

Original report signed by the inspector.