Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Sep 15, 2020	2020_834524_0015	004215-20, 006090-20, 007037-20, 007576-20, 007915-20, 008210-20, 009859-20, 016854-20, 017415-20, 017686-20	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

INA REYNOLDS (524), KRISTEN MURRAY (731)

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): August 24, 25, 26, 27, 28, September 3, 4, 8 and 9, 2020.

The following Critical Incident System (CIS) intakes were completed within this inspection:
CIS M626-000017-20 / Log #004215-20 related to medication administration
CIS M626-000020-20 / Log #006090-20 related to falls prevention and management
CIS M626-000021-20 / Log #007037-20 related to falls prevention and management
CIS M626-000022-20 / Log #007576-20 related to allegations of abuse
CIS M626-000023-20 / Log #007915-20 related to allegations of neglect
CIS M626-000024-20 / Log #008210-20 related to allegations of abuse
CIS M626-000026-20 / Log #009859-20 related to a resident to resident altercation
CIS M626-000036-20 / Log #016854-20 related to a resident to resident altercation
CIS M626-000038-20 / Log #017415-20 related to an unexpected death
CIS M626-000039-20 / Log #017686-20 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, Nurse Managers, Registered Practical Nurses, Personal Support Workers and residents.

The inspector(s) also observed resident care provisions, resident and staff interactions, reviewed clinical healthcare records including assessments and care planning interventions for identified residents, the home’s investigation notes and relevant policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **3 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	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. 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 written policy to promote zero tolerance of abuse of residents was complied with for a resident.

The home's abuse policy required staff to report immediately to the Director of Nursing or their designate any witnessed incident of abuse of a resident.

A staff member witnessed their co-worker verbally abuse a resident while providing assistance to the resident during a meal service. The staff member said in a written statement that they were shocked and upset that this had happened and reported to a Nurse Manager (NM) two days later, when they were in next.

The NM confirmed that they had reviewed an email two days after the abuse incident occurred. The NM said that the abuse was not reported as an immediate alert to the Nurse Manager on call and should have been. The NM said there was no apparent negative impact on the resident as their cognition was poor.

Sources: critical incident report; "Resident Protection (RES) – Preventing Resident Abuse" policy; investigation notes; interview with the Nurse Manager. [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 the written policy to promote zero tolerance of abuse of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted.

A resident was found kneeling on the hallway floor as a result of a resident to resident altercation. A post-fall assessment was not completed for the resident following the altercation. The home's fall prevention policy required a member of the registered nursing staff to complete a post fall assessment immediately after becoming aware of a resident fall, including a suspected fall.

Sources: "Medical Care – Fall Prevention" policy; critical incident report; the resident's progress notes; the home's incident report; interviews with a Registered Practical Nurse, and a Nurse Manager. [s. 49. (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 when a resident has fallen, a post-fall assessment is conducted, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse investigation related to a resident were reported to the Director.

A resident reported an alleged incident of physical and emotional abuse by a personal support worker to a Nurse Manager. An external investigation was completed and follow-up actions were initiated with the staff member involved. The amended critical incident did not include the results of the investigation and stated, “Will update once investigation is complete.”

Two Nurse Managers reviewed the critical incident report and acknowledged that the results of the investigation were not reported to the Director.

Sources: critical incident report; “Resident Protection (RES) – Preventing Resident Abuse" policy; investigation notes; the Long-Term Care Homes Critical Incident System in ltchomes.net; interviews with the resident, and Nurse Managers. [s. 23. (2)]

Issued on this 16th day of September, 2020

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

Original report signed by the inspector.