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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Jun 22, 2021	2021_790730_0021	004392-21, 005778-21, 007133-21, 008508-21	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

CHRISTINA LEGOUFFE (730), 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): June 8, 9, 10, 11, 14, 15, and 16, 2021.

The purpose of this inspection was to inspect the following:

-Log #004392-21, CIS #M626-000015-21 related to an allergic reaction with a transfer to hospital.
-Log #005778-21, CIS #M626-000016-21 related to an allegation of staff to resident neglect.
-Log #007133-21, CIS #M626-000018-21 related to falls prevention.
-Log #008508-21, CIS #M626-000020-21 related to an allegation of staff to resident neglect.

Inspections were also completed related to Infection Prevention and Control (IPAC) and Cooling and Air Temperature.

During the course of the inspection, the inspector(s) spoke with the Director of Senior Services (DSS), the Director of Nursing (DON), Nurse Managers (NMs), the Maintenance Supervisor (MS), the Supervisor of Food Services (SFS), a Contractor, a Scheduler, a Physiotherapist (PT), a Dietary Aide (DA), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

During the course of this inspection the Inspectors observed the overall cleanliness and maintenance of the home, observed staff to resident interactions, observed the provision of care, observed infection prevention and control practices, reviewed relevant resident clinical records, reviewed relevant internal records and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Pain
Reporting and Complaints
Safe and Secure Home

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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a resident, who required continence care products had sufficient changes to remain clean, dry and comfortable.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long Term Care (MLTC) reporting alleged staff to resident neglect, related to a lack of continence care provided to several residents.

The home identified, through an internal investigation, that Point of Care (POC) records for the resident's toilet use, hourly resident observation (Q 1 hour), bladder continence and scheduled toileting tasks had been falsified on a specified date. The home's camera system was reviewed by the home during their internal investigation and showed that Personal Support Workers did not enter the resident's room throughout their night shift. In an interview with a Nurse Manager (NM), a PSW confirmed they never entered the resident's room during their shift, they did not observe the resident and they did not provide the resident with their required continence care as per the plan of care or legislative requirements.

The NM confirmed that the PSW falsified POC records, did not follow the resident's plan of care and did not meet the home's expectation for resident continence care or legislative requirements. The risk of impaired skin integrity for the resident increased when their continence care requirements were not met.

Sources: Observations, staff interviews with a NM, the home's investigation notes, review of the resident's clinical records including plan of care and POC documentation. [s. 51. (2) (g)] (740)

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 residents who require continence care products have sufficient changes to remain clean, dry, and comfortable, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

The licensee has failed to ensure that interventions included in the home's nutrition care and hydration program were implemented to mitigate the risks of food allergies for a resident.

A resident was fed a food that they were allergic to by staff, when the resident had a documented allergy.

The home's policy titled "Food Service Management (FOO)- Resident Focused Dining- Responsibilities at Meal Service Time" directed Dietary Aides (DAs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs) to follow the resident diet information sheets for allergies when passing out beverages and foods.

A Nurse Manager (NM) said that when the resident was fed an allergen the DA did not follow the direction on the diet information sheet, and the PSW serving the meal did not reference the diet information sheet, as per the home's policy.

As a result of the incident there was actual harm to the resident, and they required medical intervention and a transfer to hospital as a result of their allergic reaction.

Sources: Resident clinical record, diet information sheets, the home's policy titled "Food Service Management (FOO)- Resident Focused Dining- Responsibilities at Meal Service Time" (Revised August 2016), and interviews with a Nurse Manager and other staff. [s. 68. (2) (c)] (730)

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 interventions included in the home's nutrition care and hydration program are implemented to mitigate the risks of food allergies, to be implemented voluntarily.

WN #3: 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 the policies related to falls management and Neurological Observation Routine were complied with for three residents.

O. Reg. 79/10 s. 48 (1) requires a falls prevention and management program to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10 s. 49 (1) requires that the program provides strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's policies and procedures "Medical Care-Neurological Observation Routine," last revised January 24, 2018. The fall prevention program and Neurological Observation Record (NOR) required staff to complete the NOR, which included the Glasgow Coma Scale, limb movements, pupil reaction, and vital signs, for 48 hours if a resident hit their head or had an unwitnessed fall. The policy required staff to wake up a resident during the night to complete the NOR.

A resident sustained an unwitnessed fall and a NOR was initiated. The NOR was not completed on one occasion and it indicated that the resident was sleeping.

A second resident sustained two unwitnessed falls and NORs were initiated. On one occasion the Glasgow Coma Scale and limb movements were not documented. The resident's pupil reaction and vital signs were not documented for two occasions on the day of the second fall.

A third resident sustained an unwitnessed fall and a NOR was initiated. On two occasions the resident's Glasgow Coma Scale and limb movements were not

documented.

The Director of Nursing (DON) stated that the NOR was completed for unwitnessed falls or witnessed falls where the resident hit their head. They said the NOR is documented on paper by registered staff. They said that it was their expectation that the resident was woken up to complete the NOR.

The homes failure to complete the NOR for the three residents, as per policy, placed them at risk for harm.

Sources: “Medical Care- Neurological Observation Routine” (last revised January 24, 2018); resident progress notes, NOR documentation and post fall assessments; and interviews with the DON and other staff. [s. 8. (1)] (730)

Issued on this 22nd day of June, 2021

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

Original report signed by the inspector.