Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
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London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: June 5, 2023	
Inspection Number: 2023-1621-0005	
Inspection Type: Follow up Critical Incident System	
Licensee: The Corporation of the Municipality of Chatham-Kent	
Long Term Care Home and City: Riverview Gardens, Chatham	
Lead Inspector Meagan McGregor (721)	**Inspector Digital Signature** Meagan McGregor Digitally signed by Meagan McGregor Date: 2023.06.05 11:22:08 -04'00'
Additional Inspector(s) Henry Otoo (000753)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29-31, 2023.

The following follow-up intake was inspected:

- Intake #00022963 a follow-up to Compliance Order (CO) #001 from inspection #2023-1621-0004 related to O.Reg. 246/22, s. 140 (2) with a Compliance Due Date (CDD) of April 21, 2023.

The following Critical Incident (CI) intake was inspected:

- Intake #00086199/CI #M626-000030-23 related to an incident resulting in a significant change in a resident's health status.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1621-0004 related to O. Reg. 246/22, s. 140 (2) inspected by Meagan McGregor (721)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)

The licensee has failed to ensure that staff complied with the home's Emergency Response Plan regarding code yellow when a resident was missing.

The resident left their floor in the home and was not present in the dining room during scheduled meal service. Staff were aware the resident was missing from the meal service but did not look for them or initiate a missing resident code yellow. When the resident was located there was a significant change in their condition.

Sources: the resident's clinical record, including progress notes, and care plan; the home's Emergency Response Plan; and interviews with staff.
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