

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

**London District**  
130 Dufferin Avenue, 4th Floor  
London, ON, N6A 5R2  
Telephone: (800) 663-3775

## Original Public Report

**Report Issue Date: November 16, 2023**

**Inspection Number:** 2023-1621-0007

**Inspection Type:**

Complaint  
Critical Incident  
Follow up

**Licensee:** The Corporation of the Municipality of Chatham-Kent

**Long Term Care Home and City:** Riverview Gardens, Chatham

**Lead Inspector**

Cassandra Taylor (725)

**Inspector Digital Signature**

**Additional Inspector(s)**

Debra Churcher (670)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 26, 27, 30, 31, 2023 and November 1, 2, 6, 2023

The following intake(s) were inspected:

- Follow-up - Intake: #00097119 relating to FLTCA, 2021 - s. 24 (1) Duty to protect. Compliance Order #001 from inspection #2023\_1621\_0006 CDD September 21, 2023.
- Complaint Intake: #00098749 -relating to allegations of abuse and neglect.
- Critical Incident (CI) Intake: #00099284 / CI #CM626-000064-23 - relating to allegations of abuse and neglect
- CI Intake #00099789 -CI #M626-000067-23 - relating to falls prevention and management

The following intakes were completed in this inspection: Intake #00095984, CI # M626-000058-23, Intake #00096427, CI # M626-000061-23, and Intake # 00096721, CI # M626-000062-23 were related to falls prevention and management.

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

London District  
130 Dufferin Avenue, 4th Floor  
London, ON, N6A 5R2  
Telephone: (800) 663-3775

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #001 from Inspection #2023-1621-0006 related to FLTCA, 2021, s. 24 (1) inspected by Debra Churcher (670)

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

- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Staffing, Training and Care Standards
- Reporting and Complaints
- Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Licensee must investigate, respond and act

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee failed to immediately investigate an allegation of abuse.

#### Rationale and Summary

A staff member of the home received an allegation of abuse. They recorded the allegations on the home's complaint form and reported the information to a Nurse Manager (NM). It was confirmed during a staff interview that an investigation was not initiated immediately.

Failure to initiate an immediate investigation placed the resident at risk.

**Sources:** The home's complaint form and interviews.

[725]

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

London District  
130 Dufferin Avenue, 4th Floor  
London, ON, N6A 5R2  
Telephone: (800) 663-3775

## WRITTEN NOTIFICATION: Evaluation

### NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 106 (b)

The licensee failed to ensure an annual evaluation was completed of the Prevention of Abuse and Neglect program.

#### Rationale and Summary

The Director of Care (DOC) and Administrator confirmed that the annual program evaluation of the Prevention of Abuse and Neglect program had not been completed for 2022.

Not completing an annual program evaluation could potentially have a negative impact on residents by not tracking trends, completing an analysis of all reported incidents, and improving the program where necessary.

**Sources:** Staff interview with the DOC and Administrator.  
[725]

## WRITTEN NOTIFICATION: Reporting certain matters to Director

### NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to immediately report an allegation of abuse to the Director.

#### Rationale and Summary

A staff member of the home received an allegation of abuse. They recorded the allegations on the home's complaint form and reported the information to a NM. An investigation was initiated at a later date, which involved a meeting with the Power of Attorney (POA). After the initiation of the investigation a Critical Incident (CI) report was submitted by the NM. It was confirmed during a staff interview that it was not immediately reported and should have been.

Not immediately reporting the allegation to the director placed the resident at risk.

**Sources:** The home's complaint form, the home's CI report and interviews.

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

London District  
130 Dufferin Avenue, 4th Floor  
London, ON, N6A 5R2  
Telephone: (800) 663-3775

[725]

## WRITTEN NOTIFICATION: Licensee must comply

### NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee failed to comply with Compliance Order (CO) #001 from Inspection #2023\_1621\_0006 served on September 14, 2023, with a compliance due date of September 21, 2023.

The licensee failed to ensure that resident #007 Inspection #2023\_1621\_0006/resident #003 Inspection #2023\_1621\_0007 was supervised as ordered for responsive behaviours.

### Rationale and Summary

Review of the residents documentation had shown the resident exhibited responsive behaviour towards staff on 18 separate days, with some days showing documentation of the behaviour on multiple shifts.

During an observation of the resident, they were observed sitting in their room. No staff were present in the resident's hallway or within view of the resident's room. A staff member was observed outside of the dining room and they confirmed that they were the staff member assigned to supervise the resident, they explained that there was a change in the direction and provided the specific supervision direction they had been given. The staff member confirmed that if the resident was having the responsive behaviours other residents were aware of it.

During an interview with a NM they shared that they changed the direction for the supervision. The NM also stated that they were planning to discontinue the supervision in near future. The NM indicated that they were only considering the responsive behaviours towards other residents in relation to the consecutive three month period with no responsive behaviours as required by the compliance order.

During a subsequent observation of the resident they were observed in the doorway of another residents bedroom and they were speaking to the resident and exhibiting the specific behaviour. The resident then travelled to another area of the unit where other residents were present. A staff member had not arrived in the lounge until 10 minutes after the inspector's observation was initiated. The staff member stated that they had been instructed on how to specifically supervise the resident.

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

London District  
130 Dufferin Avenue, 4th Floor  
London, ON, N6A 5R2  
Telephone: (800) 663-3775

The DOC stated that there had been an internal misunderstanding in the home and that they understood that the resident was to be supervised as ordered for all of the specific behaviours.

The licensee's failure to comply with order #001 from Inspection #2023\_1621\_0006 placed residents at risk.

**Sources:** Observations, record review and staff interviews.  
[670]

**An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001**

### **NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)**

The Licensee has failed to comply with FLTCA, 2021

**Notice of Administrative Monetary Penalty AMP #001**

**Related to Written Notification NC #004**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of \$1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

#### **Compliance History:**

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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

London District  
130 Dufferin Avenue, 4th Floor  
London, ON, N6A 5R2  
Telephone: (800) 663-3775

## WRITTEN NOTIFICATION: Policy to promote zero tolerance

### NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 103 (a)

The licensee failed to ensure that assistance or support was provided to a resident after they brought forward allegations of abuse.

O. Regs. 246/22, s. 11 (1) (b) 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, program, procedure, strategy, initiative or system, the licensee was required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, is complied with.

#### Rationale and Summary

An allegation of abuse was brought forward to the home and no additional supports were provided to the resident once becoming aware of the allegation.

The home's policy had indicated a procedure to ensure residents were assisted and supported after an alleged incident of abuse or neglect.

The homes Administrator had indicated that assisting and supporting residents after an allegation of abuse had not been a part of previous practice and no additional supports were provided as far as they knew.

Not offering or providing assistance or support to a resident after an allegation of abuse or neglect could have a potential negative impact to their overall wellbeing.

**Sources:** The home's policy and interviews.

[725]

## WRITTEN NOTIFICATION: Dealing with complaints

### NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee failed to ensure that the response to verbal complaints resolved within 24 hours included the Ministry's toll-free telephone number for making complaints about homes and its hours or service

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

London District  
130 Dufferin Avenue, 4th Floor  
London, ON, N6A 5R2  
Telephone: (800) 663-3775

and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

### **Rationale and Summary**

The home's complaint procedure policy indicated the contact information for the Ministry and patient ombudsman were not required for verbal complaints resolved within 24 hours.

The Administrator indicated the policy was incorrect and should have included the contact information for the Ministry and patient ombudsman in all complaints responses.

Not providing the contact information for the Ministry or patient ombudsman could potentially limit access to external sources if the complainant remains unsatisfied.

**Sources:** The home's complaint procedure and interview with Administrator.

[725]