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

Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: March 28, 2024
Original Report Issue Date: February 26, 2024
Inspection Number: 2023-1621-0008 (A2)
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

Amended By Cassandra Taylor (725)	**Inspector who Amended Digital Signature** Cassandra L Taylor Digitally signed by Cassandra L Taylor Date: 2024.04.10 10:26:23 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
The Licensee requested an extension of the Compliance Due Date (CDD), for Compliance Order (CO) #001.

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Lead Inspector Cassandra Taylor (725)	**Additional Inspector(s)** Debra Churcher (670) Stacey Sullo (000750) Terri Daly (115) Julie D'Alessandro (739) Adriana Tarte (000751)
Amended By Cassandra Taylor (725)	**Inspector who Amended Digital Signature**

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This report has been amended to:
The Licensee requested an extension of the Compliance Due Date (CDD), for Compliance Order (CO) #001.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 3, 4, 8-12, 15, 2024
The inspection occurred offsite on the following date(s): January 9, 10, 15, 18, 22, 23, 2024

The following intake(s) were inspected:

- Follow-up Intake: #00101966 -Follow-up #: 2 -relating to FLTCA, 2021 - s. 24 (1) Order #001 from inspection #2023_1621_0006 CDD September 21, 2023.
- Complaint Intake: #00102966 – relating to care plan concerns.
- Complaint Intake: #00101448 – relating to concerns about policy changes in the home.
- Complaint and Critical Incident (CI) Intake: #00101347 – CI #M626-000071-23 – relating to allegations of abuse and neglect.
- CI Intake: #00102638 -CI #M626-000089-23- relating to Resident-to-Resident responsive behaviours.
- CI Intake: #00102866 -CI #M626-000088-23- relating to Resident-to-Resident responsive behaviours.
- CI Intake: #00103412 -CI #M626-000091-23 - relating to Resident-to-Resident responsive behaviours.
- CI Intake: #00104647 -CI #M626-000099-23 - relating to Resident-to-Resident responsive behaviours.
- CI Intake: #00105409 -CI #M626-000102-23 – relating to Resident-to-Resident responsive behaviours.
- CI Intake: #00104995 -CI #M626-000100-23 – relating to Falls Prevention and Management.
- CI Intake: #00105653 -CI #M626-000001-24 – relating to resident elopement.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found 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:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents: Rights Care And Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iii.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iii. participate fully in making any decision concerning any aspect of their care, including any decision concerning their admission, discharge or transfer to or from a

long-term care home and to obtain an independent opinion with regard to any of those matters.

The licensee failed to ensure a resident was allowed to fully participate in making decisions concerning aspects of their care.

Rational and Summary
A resident and their family had requested a care intervention and the intervention was denied by staff.

The resident's rights were not respected when the resident was denied the opportunity to have made decisions concerning their care, when their care request was denied, on several occasions by staff.

Sources: The resident's clinical records, staff and resident interviews, and observations.
[000750]

WRITTEN NOTIFICATION: Safe and Secure Home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure the environment was kept secured for a resident.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC) which indicated that a resident was unable to get into the building for a period of time.

A review of the resident's clinical records, indicated that the resident had wandered and was an elopement risk. The goal was to keep the resident safe and an intervention was hourly observations.

During an interview with the Nurse Manager (NM) they stated that the process was not followed which allowed for the incident to occur.

Sources: Critical incident, resident's clinical records, and staff interview.
[739]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

A) The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Rational and Summary
A resident's clinical record stated that the resident was to receive a treatment and a

treatment plan was in place.

During an interview with a staff member, they stated that the resident had not received the treatment at the frequency as indicated in their clinical record.

During review of the resident's clinical record, no data entries were completed by staff for the past thirty days.

There was a risk to the resident, as the resident's clinical record stated resident was to receive the treatment at a specific interval, however after interviews with staff and record reviews which all confirmed resident had not received this intervention.

Sources: Resident clinical records and staff interviews.
[000750]

B) The licensee failed to ensure the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
A resident had known behaviours. Interventions were identified within the resident's clinical records.

During an observation the resident was found to have had the known behaviours without the intervention initiated.

Not ensuring the interventions were used placed the resident at potential risk of adverse effects.

Sources: The resident's clinical records, observations and staff interviews.

[725]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee failed to ensure that the outcomes of an intervention for a resident were accurately documented as set out in the plan of care.

Rationale and Summary
An intervention was documented for a resident.

During an interview with NM they acknowledged that the resident would not have been on the unit between the time of documentation, and therefore the documentation did not accurately reflect the intervention.

Sources: The **residents clinical records and staff interviews.**
[739]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of

care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee failed to ensure that the plan of care was revised when a resident's care needs changed.

Rationale and Summary
A resident was identified as having a significant change in status after an event. The resident was readmitted to the home, and required additional care in multiple care areas. Readmission assessments were completed and the care plan was not updated to accurately reflect all the required care changes until a few days later.

During an interview with Director of Care (DOC), they indicated the expectation would have been for staff to have updated the plan of care after the resident's care needs were assessed. The DOC confirmed the plan of care should have been updated sooner.

Not updating the plan of care once the resident's care needs were assessed placed the resident at risk of harm from inappropriate direction to staff for care tasks.

Sources: Resident's clinical records and staff interviews.
[725]

WRITTEN NOTIFICATION: Reporting to the Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that suspected incompetent treatment of a resident was immediately reported to the Director.

Rationale and Summary
A CI report was submitted to the MLTC. The CI also included that the Ministry of Long-Term Care after hours pager was not contacted about this Incident.

During an interview with the NM they stated that the incident should have been immediately reported to the Director and was not.

Sources: The CI report, resident clinical records, and an interview with the NM. [739]

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

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,

(b) is complied with.

A) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy was complied with.

Rationale and Summary
Review of a resident's clinical record showed that the resident was due for a head injury routine assessment to be completed at specific intervals. No documentation of the required assessments could be located of the resident's oxygen level, blood pressure, pulse or temperature at the required time. No documentation could be located of the resident's limb movement at the required time, and vital signs or pupil reaction at the required time.

A registered staff member stated that a head injury routine assessment should have been done if there was an unwitnessed fall, a blow to the head, or the resident hit their head and the head injury routine assessment should have been done per the schedule at the top of the head injury routine form.

Review of the home's head injury routine form showed that a head injury routine assessment should have been completed every 30 minutes for two hours, every hour for six hours, every four hours for 16 hours then every eight hours for 24 hours.

The home's Fall Prevention Policy stated "Initiate Neurological Observation Record for all unwitnessed falls and witnessed falls that have resulted in a head injury. All neurological assessments must be completed by the assigned registered staff according to the document timeline. No neuro check shall be missed even if resident is sleeping. If the resident refuses, an objective progress note must be made in PCC detailing health condition".

Sources: The resident's clinical record, interview with registered staff and the home's Fall Prevention Policy.
[670]

B) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy, was complied with.

Rationale and Summary
Review of a resident's clinical record showed that the resident was due for a head injury routine assessment to be completed at specific intervals. No documentation was located of the resident's glasgow coma scale and limb movements at the required times.

A registered staff member stated that a head injury routine assessment should have been done if there was an unwitnessed fall, a blow to the head, or the resident hit their head and the head injury routine assessment should have been done per the schedule at the top of the head injury routine form.

The NM stated that if the head injury routine assessments were done they would have been documented on the head injury routine forms.

Review of the home's head injury routine form showed that a head injury routine assessment should have been completed every 30 minutes for two hours, every hour for six hours, every four hours for 16 hours then every eight hours for 24 hours.

The home's Fall Prevention Policy stated "Initiate Neurological Observation Record for all unwitnessed falls and witnessed falls that have resulted in a head injury. All

neurological assessments must be completed by the assigned registered staff according to the document timeline. No neuro check shall be missed even if resident is sleeping. If the resident refuses, an objective progress note must be made in PCC detailing health condition".

The home's failure to follow the policy related to neurological observations placed two residents at risk for undetected neurological injury and delayed treatment.

Sources: Resident's clinical record, interview with staff and the home's Fall Prevention Policy.
[670]

WRITTEN NOTIFICATION: Required Programs- Pain Management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The Licensee failed to ensure that a resident's pain assessments instrument specifically designed for this purpose were completed.

Rational and Summary
A pain mapping assessment was ordered for three days for a resident.

During record review of the resident's pain mapping assessments registered staff, confirmed the ordered pain mapping assessment tool on the resident was

incomplete.

A registered staff member confirmed the expectation for all nurses completing the pain mapping assessment tool were to complete the paper copy tool as noted on the assessment, and then each shift the nurse was to document in PCC a note titled pain mapping in the resident's progress notes for three days.

There was a risk to the resident, as the pain assessment was not completed as ordered.

Sources: The resident's clinical records and staff interviews.
[000750]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident.

The licensee failed to ensure that the names of the staff members involved in an incident were included within the CI report.

Rationale and Summary
The home submitted a CI report to the MLTC which did not include the names of the staff members involved.

During an interview with DOC and Administrator they both acknowledged the information was not included in the report and should have been.

Not including the appropriate information within the CI report does not allow for proper information sharing and tracking.

Sources: CI report and staff interviews.
[725]

COMPLIANCE ORDER CO #001 Duty to protect

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must:
- Develop a written process to ensure that residents exhibiting responsive behavior towards other residents are assessed for the need to have specific interventions.
- This process should include the following:
- Clearly defined roles, responsibilities and timelines.

- A multidisciplinary assessment, involving front line staff, Behavioral Support Ontario staff and management.
- Criteria to determine the risk a resident poses to other residents when exhibiting behaviours and how these criteria would be used to determine whether the specific intervention should be initiated.
-All PSW's, RPN's, RN's, BSO staff, Nurse Managers and any other relevant staff members that would be involved in the process will be educated on the process developed.
-A record of the education provided that includes the date and name of the staff educated will be kept onsite and readily available.

Grounds
The licensee has failed to protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), (c) the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
A resident was involved in multiple incidents of resident to resident responsive behaviours.

The resident's physician ordered for specific interventions.

A staff member stated that all interventions that had been tried for the resident had been ineffective in managing their responsive behaviours.

During an interview with Behavioral Supports Ontario (BSO) staff they shared that

the resident was a risk to other residents and that BSO has no involvement with the decision to implement a specific intervention. That would have been a decision made by the NM and DOC.

During an interview with the DOC they stated that if staff felt that a specific intervention was required they would come to the NM with the request and a decision would have been made based on the resident's needs and risk. The DOC shared that the home did not have a process to identify when this specific intervention should have been considered or implemented. The DOC and NM stated that they had not been approached regarding specific intervention for the resident until the physician wrote an order.

Sources: Resident clinical records and staff interviews.
[670]

This order must be complied with by April 19, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500, 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 a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

A CO was issued to inspection # 2022_1621_0001 CCF -16-Jun-22 FLTCA s. 24. (1) - no AMP was issued.
A CO was issued to Inspection #2023-1621-0006 CCF -- 12-Sep-23 FLTCA s. 24. (1) - no AMP was issued.

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.

COMPLIANCE ORDER CO #002 Residents' Bill of Rights

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
-A description of how the home will monitor on an on-going basis that the staff of the home understand and comply with their policies relating to specific identified topics.
-A timeline of how often the monitoring will take place.
-Identify who will be responsible for implementing the monitoring process and addressing any deficiencies identified.
-Maintain a written record of the monitoring including the date, person responsible and any actions taken in response to the identified deficiencies.

Grounds
The licensee failed to ensure that staff complied with residents rights.

Rationale and Summary
Through an investigation of a reported incident, group of staff were identified to have violated resident's rights.

During interviews with the Administrator and DOC they expressed their disappointment in the staff, and they confirmed the actions of the staff were in violation of the resident's rights.

Not following the Resident's bill of rights placed the residents involved at risk.

Sources: Complaint package, the home's internal investigation notes, and staff interviews with the Administrator and DOC.
[725]

This order must be complied with by March 29, 2024

NOTICE OF RE-INSPECTION FEE Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Follow-up intake #00101966 relating to Follow-up #2 - For CO #001 FLTCA, 2021 - s. 24 (1). Order #001 from inspection #2023_1621_0006 CDD September 21, 2023.

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.