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

Original Public Report

Report Issue Date: June 25, 2024	
Inspection Number: 2024-1621-0002	
Inspection Type: Complaint Critical Incident	
Licensee: The Corporation of the Municipality of Chatham-Kent	
Long Term Care Home and City: Riverview Gardens, Chatham	
Lead Inspector Julie Lampman (522)	**Inspector Digital Signature**
Additional Inspector(s) Loma Puckerin (705241) Aurelia Pristoleanu (000833)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3, 4, 7, 10, 11, 12, 13, 14, 2024
The inspection occurred offsite on the following date(s): June 4, 7, 14, 2024

The following intake(s) were inspected:

- Intake: #00114923/Critical Incident (CI) report M626-000033-24 related to the fall of a resident;
- Intake: #00116286 related to a complaint regarding alleged resident abuse by staff;
- Intake: #00116589/CI M626-000040-24 related to resident abuse;
- Intake: #00116752 related to a complainant regarding resident care;

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- Intake: #00117178/CI M626-000044-24 related to the fall of a resident;
- Intake: #00117577 related to a complaint regarding resident care.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

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Rationale and Summary
A resident was observed receiving a treatment. Inspector #705241 inquired when the resident had started the treatment since a review of the resident's clinical record did not indicate that they were to receive the treatment.

A review of the resident's Point Click Care (PCC) medication record, treatment record and care plan, and the resident's orders indicated there was no documentation of the treatment.

In an interview with a Registered Nurse (RN) it was stated that a nurse from an outside agency had initiated the treatment for the resident and that there was presently no order for the resident to receive the treatment. The RN stated that a doctor's order was needed for a resident to receive the treatment and that it was not a treatment that they provided in the home.

In an interview with the RN it was stated that there was presently no clinical indication that the resident needed to have the treatment and that the home's physician had not written an order for the resident to receive it.

In an interview with the Medical Doctor (MD) it was stated that there was presently no clinical indication for the resident to receive the treatment and that they had not written an order for the treatment. The MD stated that the resident receiving a treatment that was not needed put the resident at risk.

There was risk to the resident due to staff and others involved in their care not collaborating in the assessment of the resident.

Sources: Review of the clinical records and interviews with the home's staff.

[705241]

WRITTEN NOTIFICATION: Fall Prevention and Management

NC #002 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 has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A resident's plan of care and point of care task indicated that the resident used a specific fall prevention intervention.

During an observation of the resident the fall prevention intervention was observed not to be in place.

A Personal Support Worker (PSW) stated that the resident should have the specific fall prevention intervention in place.

The Falls Lead also stated that the specific intervention was one of the interventions for fall prevention for this resident.

There was a risk to the resident when a fall prevention intervention was not in place.

Sources: Clinical records for the resident, observations of the resident and

interviews with PSWs, and the Falls Lead. [000833]

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

Rationale and Summary
Another resident's plan of care indicated that the resident used a specific fall prevention intervention.

During an observation of the resident the fall prevention intervention was observed not to be in place.

A Personal Support Worker (PSW) in the home area confirmed that the resident currently did not have the specific fall prevention intervention in place. The fall prevention intervention was put in place the next day by the Nurse Manager.

There was a risk to the resident when a fall prevention intervention was not in place.

Sources: Clinical records for the resident, observations of the resident. [000833]

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a resident was protected from abuse by anyone.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC) for an incident of resident abuse.

In an interview, the resident stated that they had been abused and that they felt intimidated.

Review of the home's investigation notes and interviews with a Registered Nurse (RN) and the Director of Senior Services (DSS) indicated that abuse had occurred.

Not protecting the resident from abuse posed a moderate risk to the resident.

Sources: Interview with the resident, the home's staff; Review of the home's investigation file; and the CI. [705241]