Ontario

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

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Public Report

Report Issue Date: November 26, 2024
Inspection Number: 2024-1621-0005
Inspection Type: Complaint Critical Incident
Licensee: The Corporation of the Municipality of Chatham-Kent
Long Term Care Home and City: Riverview Gardens, Chatham

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 12, 13, 14, 18, 19, 21, 2024

The following intake(s) were inspected:

- Intake: #00125519 - CIS# M626-000078-24 - related to responsive behaviors.
- Intake: #00127714 - CIS# M626-000086-24 - related to an outbreak.
- Intake: #00127869 - CIS# M626-000087-24 - related to responsive behaviors.
- Intake: #00128135 - CIS# M626-000089-24 - related to responsive behaviors.
- Intake: #00129680 - CIS# M626-000091-24 - related to responsive behaviors.
- Intake: #00131103 - CIS# M626-000094-24 - related to responsive behaviors.
- Intake: #00131376 - Complainant related to alleged failure to address a complaint and failure to follow the plan of care.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
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, iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure resident's personal health information was kept confidential.

Rationale and Summary:
During observation a cart with resident charts was in a public area of the home. Resident names and personal health information were visible and could be seen by residents and visitors passing by.

During interview with the Director of Care (DOC) they confirmed the resident's personal health information should not have been visible to the public.

The non-compliance was remedied when a staff member turned the charts over resulting in the personal health information being covered.

Sources:

Observation and interviews.

Date Remedy Implemented: November 14, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident.

Rationale and Summary:
A residents plan of care and kardex stated the resident was to receive an intervention at specific times during the day.

Review of the residents progress notes showed that the resident and their person of significant importance had brought forward multiple concerns that the intervention was not consistently being completed and staff had informed them that the intervention would not always be completed.

The resident was observed in their room without the intervention in place on multiple occasions.

During an interview with a PSW they shared that they could not always complete the intervention and that recently they had things that had changed and they were no longer completing the intervention at the specific times listed in the plan of care and kardex.

Failure to ensure the plan of care clearly set out the planned care for the resident placed the resident at risk for discomfort.

Sources:
A resident's clinical record, observations and interviews.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives

concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward to the Director any written complaint that it received concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

Rationale and Summary:
The Ministry of Long-Term Care received a complaint related to concerns that the complainant had made multiple complaints to the home expressing concerns related to the care of a resident with no resolution.

A review was completed of multiple complaint emails that had been received by the home.

This inspector was unable to locate any Critical Incident System (CIS) reports related to any of the submitted complaints.

During an interview with a Nurse Manager (NM) they stated they did not submit anything to the Director as they did not consider the emails to be complaints. The Director of Care (DOC) acknowledged that the home should have submitted the complaints.

Failure to submit a CIS to the Director poses a risk that there could be ongoing concerns that are not addressed.

Sources:

Review of the submitted complaint, review of submitted emails and interviews.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure a resident received a weekly skin and wound assessment after experiencing altered skin integrity.

Rationale and Summary:
Review of the resident's skin and wound assessments showed missing weekly assessments. An RPN confirmed that a skin and wound assessment should have been completed weekly.

Sources:
A resident's skin and wound assessments and an interview.

WRITTEN NOTIFICATION: Pain Management

NC #005 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 has failed to ensure when five resident's pain was not relieved by initial interventions; that the resident was assessed using a clinically appropriate pain assessment instrument specifically designed for this purpose.

Rationale and Summary:
Review of pain mapping for five residents who had experienced injuries showed that the pain mapping was not always completed hourly for the residents as there were multiple missed assessments.

In an interview with a NM they confirmed registered staff are required to assess pain and document hourly on the Pain and Symptom Monitoring Tool.

There was a low risk to the five resident's as pain mapping assessments were not completed hourly throughout the required three-day timeframes.

Sources:
Critical Incident reports, five resident clinical records and interviews.

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Rationale and Summary
A resident had been assigned to have a specific intervention in place.

During a reported incident on a specific date the resident did not have the intervention in place. During an observation the resident was observed without the intervention in place.

The resident's care plan indicated they were to have the intervention in place during specific times daily. A NM confirmed that the resident should have had the intervention in place at the time of the incident and at the time of the observation.

By failing to ensure the resident had the required intervention in place posed a risk to the resident and other residents.

Sources:
Critical Incident System report, a residents clinical record, observations and interviews.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:
The response provided to a person who made a complaint shall include, the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010, an explanation of what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

Rationale and Summary:
The Ministry of Long-Term Care received a complaint related to concerns that the complainant had made multiple complaints to the home expressing concerns related to the care of a resident with no resolution.

A review was completed of multiple complaint emails that had been received by the home. No response including the required information was found. During an interview the a NM they confirmed that they did not provide the complainant with the required information.

Failure to respond to a complaint per the legislative requirements poses a risk that the home will not respond to complaints appropriately.

Sources:
Review of multiple emails and complaints and interviews.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the

action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee has failed to ensure that a documented record is kept in the home that included:
- the nature of each verbal or written complaint;
- the date the complaint was received;
- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- the final resolution, if any;
- every date on which any response was provided to the complainant and a description of the response; and
-any response made in turn by the complainant.

Rationale and Summary:
The Ministry of Long-Term Care received a complaint related to concerns that the complainant had made multiple complaints to the home expressing concerns related to the care of resident #009 with no resolution.

A review was completed of multiple complaint emails that had been received by the home. Review of the homes 2024 complaints binder showed no complaints were logged for the month the home received the complaints.

During an interview with the DOC they shared that the complaints should documented and included with the homes 2024 complaints.

Failure to document complaints poses a risk that the home will not be able to complete an accurate analysis or identify trends in the home.

Sources:
Complaint binder, emails and interviews.

WRITTEN NOTIFICATION: Resident Records

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that the a resident's written record was kept up to date at all times.

Rationale and Summary:
During an interview with a NM they stated that they had had a conversation with the resident three to four days prior to the interview where the resident was notified of a trial change in their plan of care and that the resident was agreeable to the change.

This Inspector was unable to locate any documentation of the conversation in the resident's clinical record. When asked if this conversation had been documented the NM stated that they had not documented in the resident's clinical record.

Failure to document in the resident's clinical record posed a risk of staff not being aware that a trial change was being implemented.

Sources:
The resident's clinical record and interviews.