Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 24, 2017	2017_538144_0010	019060-16, 021897-16, 033115-16	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE MUNICIPALITY OF CHATHAM-KENT
519 King Street West CHATHAM ON N7M 1G8

Long-Term Care Home/Foyer de soins de longue durée

RIVERVIEW GARDENS
519 KING STREET WEST CHATHAM ON N7M 1G8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 28, 2017.

This critical incident inspection was related to falls prevention and management. Critical Incidents M626-000009-16, M626-000031-16 and M626-000056-16 were reviewed.

During the course of the inspection, the inspector(s) spoke with the Director of Senior Services, Director of Nursing, one Nurse Manager, the Administrative Assistant, Medical Secretary, two Registered Nurses, one Registered Practical Nurse (and one Personal Service Worker.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident had been assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home's Fall Prevention Policy last revised November 25, 2016, stated under Post Fall Procedures that registered staff would complete a post fall assessment immediately after becoming aware that a resident had fallen even if they became aware at a later date.

The clinical record for a resident stated that the resident had experienced falls. The clinical record did not include post fall assessments for the resident

Two Registered Nurses (RN's) told the Inspector that incident reports and post fall assessments were to be completed after each resident fall.

The Director of Nursing (DON) and one Nurse Manager (NM) acknowledged that the home's expectation was that a post fall assessment would be conducted for each resident after each fall.

2. The clinical record for a second resident stated that the resident had also experienced falls. The clinical record for the second resident did not include a post fall assessment for one fall.

One RN told the Inspector that post fall assessments were to be completed each time a resident had fallen.

The DON and one NM acknowledged that a post fall assessment was not completed for one of the second resident's falls.

The NM further acknowledged that when a resident had fallen more than once in a 24 hour period, a fall assessment would be conducted for each fall.

The severity of this issue was level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a pattern during the course of this inspection.
The home does not have a history of non-compliance with this subsection of the regulation. [s. 49(2)]

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Issued on this 12th day of April, 2017

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.