



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

**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**

London Service Area Office  
130 Dufferin Avenue 4th floor  
LONDON ON N6A 5R2  
Telephone: (519) 873-1200  
Facsimile: (519) 873-1300

Bureau régional de services de  
London  
130 avenue Dufferin 4ème étage  
LONDON ON N6A 5R2  
Téléphone: (519) 873-1200  
Télécopieur: (519) 873-1300

**Public Copy/Copie du public**

---

<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Nov 24, 2017	2017_538144_0047	024033-17	Complaint

---

**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**

---



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

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

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): November 9, 10, 2017**

**This complaint inspection was related to falls prevention and management, staffing and critical incident reports.**

**During the course of the inspection, the inspector(s) spoke with the Director of Nursing, one Nurse Manager, three Registered Practical Nurses and three Personal Support Workers.**

**During the course of the inspection, the Inspector reviewed one resident clinical record and the home's falls prevention and management program.**

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

**Critical Incident Response**

**Falls Prevention**

**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.**

**Plan of care**

**Specifically failed to comply with the following:**

- 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; 2007, c. 8, s. 6 (1).**
  - (b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
  - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**



**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written plan for a resident set out clear directions to staff and others who provided direct care to the resident.

A complaint, IL-53532-LO was submitted to the Ministry of Health and Long-Term Care related to falls prevention and management, staffing and critical incident reports.

Review of the clinical record for a resident stated that the resident experienced a fall on an identified date.

The resident progress notes identified that the resident's daughter informed one RPN by telephone on an identified date that the resident would require an assistive device.

A physician's note was provided to the home on an identified date advising the resident required an assistive device.

The resident was observed by the Inspector on two identified dates using an assistive device.

The current MDS quarterly review for the resident included that the resident was independent and did not require an assistive device.

The current care plan for the resident included that the resident was independent and required an assistive device for long distances.

Two RPN's shared that since the fall, the resident was no longer independent and required an assistive device.

Three PSW's told the Inspector that the resident was no longer independent and used an assistive device all of the time.

The DON stated that the care plan for the resident should have been revised to provide staff with clear direction related to the resident's needs.

The licensee has failed to ensure that the written plan for a resident set out clear directions to staff and others who provided direct care to the resident.

The severity of this issue was determined to be a level two with minimal harm or potential



Ministry of Health and  
Long-Term Care

Ministère de la Santé et des  
Soins de longue durée

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

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

for actual harm. The scope of this was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 23, 2017, as a written notification with complaint inspection 2017-605213-0010. [s. 6. (1) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

---

Issued on this 4th day of December, 2017

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

**Original report signed by the inspector.**