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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 17, 2019	2018_532590_0025	005255-18, 006501-18, 007063-18, 009081-18, 016025-18, 016439-18, 016544-18, 016713-18, 021733-18, 022187-18, 027369-18, 029540-18, 030240-18	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

ALICIA MARLATT (590), CASSANDRA TAYLOR (725), HELENE DESABRAIS (615)

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): November 13 - 16, 19 - 23, 26 and 27, 2018.

The following intake was completed during this Critical Incident System inspection: Log #025956-18 was related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, two Nurse Managers, one Chaplain, two Registered Nurses, one Registered Practical Nurse, eight Personal Support Workers and one Nursing Student.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, Critical Incident System reports, internal investigation notes, policies and procedures relevant to inspection topics, employee records, staff training records and incident reports.

During the course of the inspection, the inspector(s) observed mechanical lift transfers, staff and residents' interactions, infection prevention and control practices and resident rooms for specific interventions to be in place.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC).

Information contained within the CIS report stated that resident #010 was walking with Personal Support Worker (PSW) #116 when they became weak and were lowered to the floor. Later resident #010 was showing signs of pain and was transferred to the hospital where it was determined the resident sustained an injury. Resident #010's family member questioned the incident and the injury that had occurred which prompted the home to initiate an investigation.

A second CIS report was submitted to the MOHLTC two days after the first report.

Information contained within the new CIS report was unclear regarding the findings of the incident.

During a record review of the homes internal investigation notes it was found that PSW #116 had falsified the actual occurrence of the incident and did not follow the falls policy. It was determined that PSW #116 was walking with resident #010 when resident #010 fell and in fact was not lowered to the floor. PSW #116 attempted to pick up resident #010 unsuccessfully by themselves on four separate occasions, when finally another staff member had come to assist. The nurse on duty was contacted to assess the resident and then the resident was assisted up with a mechanical lift and placed into a wheelchair. Later that day resident #010 began to exhibit signs of pain and was transferred to the hospital where it was determined the resident sustained an injury.

During a record review of the homes policy titled 'Resident Protection (RES) – Resident Abuse', Policy Code: ADM RES, last revised in July, 2014, it defined neglect as "Neglect, means the failure to take action to provide the care and assistance required for the health

or safety of a Resident. "Neglect" includes a pattern of neglect that jeopardizes the health or safety of one or more Residents. The term "Neglect" includes, but is not limited to, the failure to: Provide the care set out in the Resident's plan of care, Ensure the provision of medical care when required, Reduce and manage health and safety hazards, implement programs to prevent existing health-care problems in the facility, such as pressure ulcers, dehydrations, and unplanned weight loss, Summon assistance when required."

During an interview with Nurse Manager (NM) #101 the surveillance video was viewed. NM #101 confirmed from watching the video, that the resident had fallen and that PSW #116 did attempt to pick up resident #010 unsuccessfully on four separate occasions by themselves. NM #101 stated that this incident was neglect.

The licensee had failed to ensure that resident #010 was not neglected by the licensee or staff. [s. 19. (1)]

2. A CIS report was submitted to the MOHLTC documenting an incident that occurred of resident to resident abuse which caused injuries to one of the involved residents. The report documented that resident #007 was witnessed by a staff member to have slapped resident #006 and that bruising had developed during the night.

Ontario Regulation 79/10 defined physical abuse as:
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident.

Review of resident #007 and 006's clinical record showed that both residents had moderately impaired cognition at the time of the incident.

Review of resident #006's progress notes showed documentation of staff members. The staff had documented that resident #007 was witnessed by a staff member to have slapped resident #006. The residents were immediately separated and resident #006 was assessed for injuries by completing a head to toe assessment and vital signs. The staff documented that a red mark was observed on resident #006 and pain mapping was initiated to monitor the resident for pain. Both residents' Substitute Decision Makers (SDM), and the police were notified of the incident. During the night, staff documented that resident #006 had developed bruising. Resident #006's bruising was monitored by registered staff until it resolved as evidenced by completed weekly skin assessments.

Review of the homes' abuse policy titled 'Resident Protection (RES) – Resident Abuse', policy code: ADM RES, and last revised in July 2014, showed a definition of physical abuse of a resident, which "means any action of physical force or restraint that is contrary to the Residents' health, safety, and well-being, and that may inflict pain and/or injury to the Resident." Further, the abuse policy documented that physical abuse included, but was not limited to slapping.

In an interview with the Director Of Nursing (DON) #100, they agreed with the Inspector that resident #007 had caused injuries to resident #006, and that the police and both SDM's had been notified of the incident. [s. 19. (1)]

3. A CIS report was submitted to the MOHLTC documenting an incident that occurred in the early afternoon, of resident to resident abuse which caused injuries to one of the involved residents. The report documented that resident #007 was witnessed by a staff member, injuring resident #008.

Review of resident #007's clinical record showed that the resident had moderately impaired cognition at the time of the incident.

Review of resident #008's progress notes showed documentation of staff members. A PSW had witnessed the altercation and described that resident #007 was at resident #008's table and had unexpectedly and quickly injured resident #008. The residents were immediately separated and first aid was provided to resident #008.

After the altercation the home notified both residents' SDM's, the physician, the police and the MOHLTC. Resident #008 was ordered antibiotics as a proactive measure to prevent infection by their physician and pain mapping was initiated to monitor for pain. The resident required dressings to the injury until it healed.

Review of the homes' abuse policy titled 'Resident Protection (RES) – Resident Abuse', policy code: ADM RES, and last revised in July 2014, showed a definition of physical abuse of a resident, which "means any action of physical force or restraint that is contrary to the Residents' health, safety, and well-being, and that may inflict pain and/or injury to the Resident."

In an interview with the DON #100, they agreed with the Inspector that resident #007 had caused injuries to resident #008, and that the police and both SDM's had been notified of

the incident.

The licensee had failed to ensure that resident #006 and #008 were protected from abuse by resident #007. [s. 19. (1)]

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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee had failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS report was submitted to the MOHLTC which documented that an incident of improper or incompetent treatment of a resident resulted in harm or risk of harm to resident #001.

Review of resident #001's clinical record showed that the resident fell in the tub room and was sent to the hospital for further assessment. The resident required surgery after this fall. The residents' lift and transfer assessment completed prior to the fall, and their care plan, documented that this resident was a two person passive mechanical lift for all transfers.

Review of the homes' policy titled 'Medical Care – Resident Transfers' with policy code NUR MED and last revised on December 12, 2017, documented in a section titled "Transfer Lift Method For Residents Into/Out Of Tub" that "All transferring of Residents using an active or passive lift into and out of the tub require a two person assist for these transfers. Once the resident is placed safely in the tub one staff can bathe the Resident and call for help once completed the bath. When using the tub/shower staff must follow the operating and product care instructions. (Manuals are on units)."

Review of the homes' internal investigation notes showed that several staff members were interviewed after this incident. The staff member completing the transfer had admitted to not having two people present for the transfer and also admitted to not using the mechanical lift during the transfer. The staff member had stated that they were aware of this resident's transfer status prior to the transfer.

In interviews with PSW's #102 and 103, they both shared that they were aware of the homes' lift and transfer policy and of the requirement to have two people present to use the mechanical lifts for safety purposes.

In an interview with DON #100, they shared that after the internal investigation, the staff member had been terminated. The DON shared that the staff member had violated the homes' Transfer and Lift policy, which resulted in injury to a resident.

The licensee had failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A CIS report was submitted to the MOHLTC reporting an incident of abuse.

Information included in the CIS report stated that PSW #113 was overheard by a visiting family member, to be speaking inappropriately to resident #009 and telling them they would have to wait for care. The family member approached PSW #111 who promptly attended to resident #009.

During a record review of the homes internal investigation notes the home became aware of the incident the day prior to the CIS report being submitted, when the same family member that overheard PSW #113 reported to the Registered Nurse (RN) #117.

During an interview with the DON #100 and NM #118 it was confirmed that the home became aware of the alleged verbal abuse on the day prior to it being reported. Both the DON and NM also confirmed that abuse should be reported immediately.

The licensee has failed to ensure that the alleged incident of verbal abuse for resident #009 was reported immediately [s. 24. (1)]

Issued on this 23rd day of January, 2019

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

Original report signed by the inspector.