Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux 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
May 28, 2020	2020_607523_0012	003062-20, 003756-20	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

ALI NASSER (523), CAROLEE MILLINER (144), SAMANTHA PERRY (740)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 6, 9, 10, 11 and May 26, 2020.

This inspection was completed for the following intakes:
Complaint Log # 003756-20, IL-74943-LO, related to multiple care concerns.
Critical Incident Log #003062-20, CIS M626-000013-20, related to a resident's fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Nurse Managers, Registered staff members, Personal Support Workers, housekeeping staff members, Physiotherapist, Dietary Aide, and family members.

The inspector(s) also toured the home, observed residents and care provided to them, reviewed clinical records, incident reports, investigation notes and reviewed specific policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Minimizing of Restraining
Personal Support Services
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(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. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

The Ministry of Long-Term Care received a complaint on a certain date related to specific care concerns including falls prevention.

In an interview the complainant said that upon resident's admission they informed the nurse that the resident was a high risk for falls, that they needed specific assistance and direction. The complainant suggested the use of a specific intervention.

In an interview a specific Register Nurse (RN) said that they completed the admission summary for the resident, and that they talked to the family about resident's needs and preferences, but they did not assess the resident. The RN said that the family informed them of the specific resident's needs and requested intervention but at that time they did not put that intervention in place.
The RN said that they should have put the specific intervention in place on admission. [s. 6. (2)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A) The Ministry of Long-Term Care received a complaint on a specific date related to specific care concerns including falls prevention.

A clinical record review for the resident showed different assessments that were completed by different team members. The assessments were not consistent with each other and gave different information related to the resident's needs.

In an interview a specific Nurse Manager reviewed the two assessments and said that the identified assessments were not consistent with each other and gave different information related to the resident’s specific needs. s. 6. (4) (a)] (523)

B) The Resident was admitted to the home on a specific date.

A clinical record review for the resident showed different assessments related to continence care that were completed by different team members. The assessments were not consistent with each other and gave different information related to the resident's needs.

A specific Nurse Manager stated that the continence assessments for the resident were not consistent and did not compliment each other. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the Substitute Decision Maker (SDM), if any, and the designate of the resident / SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

Clinical record review and staff interviews showed that the resident had a change in status on a certain date, the staff changed the plan of care interventions specific to continence care and bowel managment without communicating or consulting with the Power of Attorney (POA)/ SDM.

A specific Nurse Manager stated that the residents' POA should have been consulted prior to the specific change in the resident's plan of care. [s. 6. (5)]

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 plan of care is based on an assessment of the resident and the resident's needs and preferences.

-staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

-the SDM, if any, and the designate of the resident / SDM is provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The Ministry of Long-Term Care received a complaint on a specific date related to specific care concerns including falls prevention.

ONTARIO REGULATION 79/10, section 48. (1) stated “Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.”

A review of the home’s policy subject Fall Prevention, revised January 23, 2020. Under Procedure Registered Nursing Staff #1 it stated: “Collaborate with resident/substitute decision -maker (SDM) and family and interdisciplinary team to conduct the fall risk assessment in RAI-MDS 2.0 and falls assessment in PointClickCare (PCC)
• Within 24 hours of admission.
• Quarterly
• When a change in health status puts them at increased risk for falling.”

A clinical record review for the resident and staff interviews showed that fall risk assessment in RAI_MDS 2.0 was not completed withing 24 hours of the resident's admission.

In an interview a specific Nurse Manager reviewed the falls prevention policy and the resident's clinical record, they said that the fall risk assessment in RAI-MDS 2.0 should have been completed within 24 hours of the resident’s admission and that the home’s falls prevention policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #3: 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 the resident has fallen, the resident had been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The Ministry of Long-Term Care received a complaint on a specific date related to specific care concerns including falls prevention.

A clinical record review for the resident and staff interviews showed that on a specific date the resident had a fall but there was no post fall assessment completed for the resident.

In an interview a specific Nurse Manager reviewed clinical records and post fall assessments and said that there was no post fall assessment completed for the resident after the specific fall and that there should have been one completed. [s. 49. (2)]

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 when the resident has fallen, the resident had been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The Ministry of Long-Term Care received a complaint on a specific date related to specific care concerns.

In a telephone interview complainant said that the resident’s method of choice for bathing was not followed by the staff.

A clinical record review and staff interviews showed that that on a specific date the resident was not bathed by the method of their choice.

In an interview a specific Nurse Manager said that they were not able to find any documented evidence that a discussion was completed with the family to reflect changes in the resident’s bathing preference. [s. 33. (1)]

Issued on this 17th day of June, 2020

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

Original report signed by the inspector.