Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: May 3, 2024

Inspection Number: 2024-1621-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: The Corporation of the Municipality of Chatham-Kent

Long Term Care Home and City: Riverview Gardens, Chatham

Lead Inspector	**Inspector Digital Signature**
Debra Churcher (670)	Debra Churcher Digitally signed by Debra Churcher Date: 2024.05.13 06:57:19 -04'00'

Additional Inspector(s)
Stacey Sullo (000750)
Cassandra Taylor (725)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 16, 17, 18, 19, 22, 23, 24, 25, 26, 2024

The following intake(s) were inspected:
- Intake: #00106431 - Complaint related to alleged neglect.
- Intake: #00107354 - Critical Incident System report (CIS) #M626-000004-24 related to an unexpected death.
- Intake: #00107385 - Complaint related to alleged neglect.
- Intake: #00107517 - Complaint related to alleged neglect.
- Intake: #00109986 - Follow-up to CO#002 relating to- FLTCA, 2021 - s. 3

(1) 18 relating to Resident's Bill of rights privacy CDD 2024-03-29
· Intake: #00109987 - Follow-up to CO#001 - FLTCA, 2021 - s. 24 (1) relating to duty to protect. original CDD 2024-03-29. CDD amended to 2024-04-19.
· Intake: #00111256 - Complaint related to alleged neglect.
· Intake: #00111486 - CIS #M626-000016-24 related to a complaint to the home alleging neglect.
· Intake: #00111551 - CIS #M626-000018-24 related to a complaint to the home alleging neglect.
· Intake: #00111724 - CIS #M626-000019-24 related to alleged Improper/Incompetent treatment.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1621-0008 related to FLTCA, 2021, s. 3 (1) 18. inspected by Cassandra Taylor (725)

Order #001 from Inspection #2023-1621-0008 related to FLTCA, 2021, s. 24 (1) inspected by Debra Churcher (670)

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)
Plan of care
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
(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.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other 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.

Rationale and Summary:
Review of a resident's clinical record showed the resident was experiencing a medical condition resulting in the physician ordering interventions overnight on a specific date. A physician order dated two days later ordered the intervention to be

discontinued. A progress note dated for the same date as the order to discontinue the intervention stated that the resident had again developed the medical condition and therefore the intervention was not discontinued, and the physician would be notified the next day.

A Registered Nurse (RN) stated that they did not call the physician as they usually did not want to be called after a certain time of day

A Nurse Manager (NM) stated that they would have called the physician related to the intervention not being discontinued including the rationale and would not have waited until the next day.

Failure to collaborate with the physician placed the resident at risk of multiple medical complications.

Sources:
A resident's clinical record and interview with an RN and a NM.
[670]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Rationale and Summary:
Review of resident's clinical record showed that a lab sample was obtained however could not be tested as it was not labelled and another lab sample was obtained but could not be tested as it was not labelled correctly.

A NM stated that lab samples were to have the requisition and sample labelled correctly.

Failure to manage lab samples correctly placed the resident at risk of potentially receiving an ineffective treatment and a potential delay in treatment.
Sources:
A resident's clinical record and an interview with a NM.
[670]

WRITTEN NOTIFICATION: Communication and Response System

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents.

A) Rationale and Summary:
During an observation of a resident the call bell was noted to be on the bed out of the resident's reach. The resident was able to state that they use the call bell to call to go to the bathroom and was able to demonstrate the use of the call bell

Review of the resident's care plan showed instruction to reinforce the need to call for assistance and to keep the call bell within reach.

During an interview with a NM they acknowledged that the resident was to have their call bell within reach and accessible at all times when in their room.

Failure to have the residents call bell accessible placed the resident at risk of being unable to summon assistance.

Sources:
Observation of a resident and interview with a NM.

[670]

B) Rationale and Summary:
A resident's call bell was observed to be out of reach to the resident.

During an interview with a Personal Support Worker (PSW) they confirmed residents should always have their call bells within their reach at all times.

There was a risk to the resident having had no access to the communication and response system (call bell) at all times.

Sources:
Staff interview, and resident observation.
[000750]

C) Rationale and Summary:
A resident's call bell was observed to be out of reach of the resident on three separate occasions.

Two PSW's confirmed that a resident's call bell should be always within the resident's reach at all times.

A NM confirmed the expectation for all staff were to ensure residents always had their call bells within reach at all times.

There was a risk to the resident having had no access to the communication and response system (call bell) at all times.

Sources:
Observations of the resident and interviews with PSW's and a NM
[000750]

WRITTEN NOTIFICATION: Oral Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)
Oral care
s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of

the home receives oral care to maintain the integrity of the oral tissue that includes, (a) mouth care in the morning and evening, including the cleaning of dentures;

Rationale and Summary:
During observations an three separate dates at differing times the resident's oral care tools were noted to be dry and the resident had oral debris.

During interviews with two PSWs both staff were unable to recall if the resident had received oral care on the dates in question but did confirm if the oral care tools were dry the resident did not receive oral care

A NM confirmed the expectation for staff were to complete oral care on the resident after breakfast and after dinner daily.

There was a risk of medical issues related to oral care not being provided.

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

[000750]

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 3.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

The licensee failed to ensure that documentation was completed for resident #005 after their catheter procedure.

11. (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,(b) is complied with.

Rationale and Summary:
A resident had a procedure completed on a specific date by RN #115 and RN #119. RN #115 wrote a progress note and RN #119 did not. The resident developed complications post procedure. RN #115 and RN #114 attended to the resident. RN #115 wrote a progress note and RN #114 did not.

An internal investigation was initiated, RN #114 and #115 were asked to put in a late entry that reflected the actions taken. RN #114 completed a late entry 8 days later. RN #115 completed a late entry 17 days later.

The homes policy related to the procedure listed specific data that was to be included in documentation post procedure and review of the late entry documentation did not include all the required data.

During an interview with the Director of Care (DOC) they indicated the expectation would have been that the staff follow the policy and should have included all the required data.

Not ensuring the policy was followed relating to documenting the procedure posed

a potential risk to the resident.

Sources:
Resident records, the home's policy and staff interviews.
[725]

WRITTEN NOTIFICATION: Reports Regarding Critical Incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5).
O. Reg. 246/22, s. 115 (4).

The licensee failed to report an injury that resulted in hospitalization and a significant change in status for a resident.

Rationale and Summary:
A resident was hospitalized after undergoing a procedure at the home and experiencing complications. The RN received report the next day that the resident was being admitted to hospital related to an injury due to the procedure done at the

home. The resident returned to the home three days later with additional medications and symptoms.

During an interview a NM indicated they were aware when they read the 24-hour report two days prior to the residents return to the home, but did not report.

The DOC indicated the incident should have been reported.

Not reporting the incident to the Director posed no risk to the resident.

Sources:
A resident's medical records and staff interviews.

[725]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that, drugs were stored in an area or a medication cart, that was secure and locked.

A) Rationale and Summary:
On April 16, 2024, a treatment cart was observed to be unattended and unlocked in the hallway with the key in the cart on the two West unit. Scissors, multiple prescription and non prescription creams and dressing supplies were observed in the cart. Residents were present in the nearby lounge.

A NM stated that they keys should not be left in the cart when and the cart should be locked when unattended.

Failure to ensure the cart was locked and secured placed residents at risk of harm as they could access the contents of the cart.

Sources:
Observation of the treatment cart and interview with a NM.

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B) Rationale and Summary
On April 16, 2024, during an observation of the three East unit the treatment cart was observed to be locked with the key inside the lock. Nurse Manager (NM) #102, indicated that the keys should not have been left in the cart.

During an observation of the three West unit the treatment cart was observed to be locked with the key inside the lock. Registered Practical Nurse (RPN) #101, removed the keys from the lock.

During an observation of the five West unit the treatment cart was observed to be unlocked with the keys inside the lock. Registered Nurse (RN) #103, indicated that the cart should have been locked and the keys removed from the lock.

a NM indicated the expectation of the treatment nurse would have been to lock the cart and remove the keys.

Not locking the treatment cart and removing the keys posed a risk to residents potentially accessing the contents of the carts.

Sources:
Observations and staff interviews.
[725]

WRITTEN NOTIFICATION: Resident records

NC #008 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 resident's written record was kept up to date at all times.

Rationale and Summary:
Review of a resident's clinical record showed that the resident was assessed by an RN who noted a specific vital sign was not within normal range however no physical assessment related to the abnormal vital sign could be located.

During an interview with the RN they shared that the believed they had done the assessment but had not documented it.

During an interview a NM they stated that all assessments should be documented.

Failure to document assessments places that resident at risk for unidentified changes in condition.

Sources:
A resident's clinical record and staff interviews.
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