



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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4ième étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

Public Copy/Copie du public

Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Dec 21, 29, 2011; Jan 9, 2012 | 2011\_089115\_0026 | Critical Incident

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

TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Acting Director of Care, 1 Registered Nurse and 1 Personal Support Worker.

During the course of the inspection, the inspector(s) reviewed the clinical record of 1 resident, reviewed related policies and procedures, and observed the resident.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Table with 2 columns: Legend and Legendé. 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



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  
prévus le Loi de 2007 les  
foyers de soins de longue

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 subsections:**

- s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,  
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision;  
and  
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

**Findings/Faits saillants :**

1. The resident had initial assessments post fall using clinically appropriate instruments, however for several days post the initial falls assessments the staff documented that the resident experienced swelling, bruising and pain associated with the affected leg. The resident was not seen by the physician or sent to hospital for further assessment until several days later where it was determined the resident had sustained more extensive injuries.  
[LTCHA 2007, c. 8, s. 6 (11)(a)]

**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 a resident is reassessed, staff collaborate with each other in the assessment of the resident, to be implemented voluntarily.***

Issued on this 9th day of January, 2012

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