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 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

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 7, 2016	2016_349590_0022	010052-16	Complaint

Licensee/Titulaire de permis

RICHMOND TERRACE LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

Long-Term Care Home/Foyer de soins de longue durée

RICHMOND TERRACE
89 RANKIN AVENUE AMHERSTBURG ON N9V 1E7

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

ALICIA MARLATT (590)

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): August 11 & 12, 2016.

Complaint IL-43910-LO was related to food quality and resident care.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), the Nutrition Manager, one Registered Nurse and one resident.

During the course of the inspection, the inspector(s) reviewed one resident's clinical record, the 2016 Spring/Summer menu and relevant policies related to inspection, observed one resident's room, the kitchen area including the food items in the cooling and freezing areas, infection prevention and control practices and staff/resident interactions.

The following Inspection Protocols were used during this inspection:
Food Quality
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident's right to be properly sheltered, fed,

clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted.

In an interview, the family of resident #045 expressed concern regarding the length of time taken to treat an infection. Resident #045 developed an infection that was treated. The resident developed this infection again a month later, however treatment was not provided until two weeks later.

Review of resident #045's progress notes revealed the following:

On a specified date the staff documented they observed signs and symptoms of infection. The note indicated the area was cleansed and the resident was added to the physician's list to be seen.
On a specified date staff documented that they observed signs and symptoms of infection and that the resident also complained of signs and symptoms of infection . The area was cleansed with water and a note was made that they were on the physicians list to be seen this week.
On a specified date staff documented that the resident complained of signs and symptoms of infection and observed discharge from the area. Warm compresses were applied at that time.
On a specified date drainage was observed by staff and the resident complained of discomfort. The area was cleansed with water and a note was made that they were on the list for the physician to see tomorrow morning.
On a specified date, the physician made a note in the resident's chart but did not order any treatment for the resident. The nursing staff documented this same day that the resident was having signs and symptoms of infection. The area was cleansed with water and the charge nurse was made aware.
On specified dates staff documented that the resident continued to have signs and symptoms of infection.
On a specified date a note was made that the resident's family approached the nursing staff inquiring why the resident had not started treatment for the signs and symptoms of infection. The family was told at that time that the resident was not on the physician's list last week and that the resident had not been complaining. It was noted that nursing staff contacted the physician and an order was received and treatment was initiated.

In an interview with resident #045 they shared that they would tell the nursing staff about their signs and symptoms of infection and hoped that they remembered to tell the doctor about them. The resident shared that the physician did not always come in and see them.

In an interview with DON #101 he confirmed that there was a breakdown in communication between the nurses and the physician and as a result there was a delay in treatment being provided. DON #101 shared that the physician does rounds once a week, and if a concern for which a resident was symptomatic had not been addressed on rounds, he would expect the nursing staff to call the physician for treatment for the resident. [s. 3. (1) 4.]

Issued on this 14th day of October, 2016

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

Original report signed by the inspector.