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 7, 2019	2018_747725_0027	021612-18	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

CASSANDRA TAYLOR (725)

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): December 6, 7, 10-12, 13 & 20, 2018.

The following intake was inspected;

Complaint Inspection: Log #021612-18 and IL-59077-LO related to transfer and positioning, plan of care, Residents' Bill of Rights, weight changes and administration of drugs.

During the course of the inspection, the inspector(s) spoke with the Vice President of Practice and Innovation (VPPI), the Resident Assessment Instrument/ Minimum Data Set Corporate Consultant (RAI/MDS CC), the Director of Clinical Service (DCS), the Director of Culinary Services, one Clinical Service Manager, one Registered Nurse, three Personal Support Workers (PSWs), one Dietitian.

During the course of this inspection the inspector observed staff to resident interactions, reviewed relevant policies and procedures and reviewed relevant clinical records and documentation.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Nutrition and Hydration
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	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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

On August 16, 2018, a complaint log #021612-18/ IL-59077-LO was submitted to the Ministry of Health and Long-Term Care (MOHLTC) pertaining to resident #001 relating to treatments not being administered as ordered.

During a record review for resident #001 an order was written by the Nurse Practitioner for a specific medication and treatment. The treatment was to continue with no specific end date and appeared on the latest three month medication review.

During a record review of the Electronic Treatment Administration Record (ETAR) for resident #001 it indicated that the treatment on five specific dates and times had a code nine with direction to see nurses notes. Nurses notes documented in Point Click Care (PCC) on the corresponding dates indicated the treatment was not completed.

During a staff interview with the Clinical Service Manager (CSM) #108 and the Director of Clinical Service #100 both confirmed the treatments should have been administered as ordered.

The licensee has failed to ensure that the treatment set out in the plan of care for resident #001 was completed as specified in the plan. [s. 6. (7)]

Issued on this 9th day of January, 2019

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

Original report signed by the inspector.