Ontario

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 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
Jul 29, 31, 2019	2019_538144_0029	013141-19	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

CAROLEE MILLINER (144)

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): July 17, 18, 19, 2019

The following intake was inspected with this inspection:
Log 013141-19 related to falls prevention and management.

The following CIS was reviewed during this inspection:
1149-000045-19 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, the Rehabilitation Services Coordinator, one Registered Practical Nurse and four Personal Support Workers.

During the course of the inspection, the inspector observed two residents and reviewed two resident clinical records and relevant home policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care for one identified resident was documented related to one specific care need.

One CI was reviewed related to an allegation of neglect in that one PSW staff had not followed up with one residents' specific care needs.

Three Personal Support Workers (PSW) and one RPN told the inspector that PSW staff document in the Point of Care (POC) program, the exact time care is provided for one identified care need.

Review of the electronic clinical record for one resident did not include documentation that PSW's monitored the resident on two specific dates and periods of time for the identified care need.

The DOC reviewed the video footage of the the corridor where the resident resides for the time periods identified by the inspector.

The DOC shared that the video footage revealed that nursing staff entered the residents' room on several occasions during the periods of review.

The DOC acknowledged that PSW staff should have documented the care they provided to the resident in the POC program. [s. 6. (9) 1.]

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 provision of the care set out in the plan of care is documented, 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

O. Reg. s.48(1) states that every licensee of a long-term care home shall ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

Staff did not comply with the licensee's Falls Prevention Post Management Policy last reviewed May 18, 2018, which provides direction for registered personnel in the event of a resident fall.

The Falls Prevention Post Management Policy stated in part that before moving a resident that had fallen, registered staff assess their level of consciousness, neurological status, range of motion, pain, vital signs and potential injury, bruising, lacerations and fracture.

One intake and CI report were reviewed related to one identified resident experiencing a fall resulting in an injury.

During the inspection, on two occasions, the inspector and Director of Care (DOC) reviewed the video footage related to the residents' fall.

Video footage of the fall revealed that one identified Registered Practical Nurse (RPN) completed an assessment of the residents' head at the location of the fall.

Review of the video footage of the fall did not include an assessment by the RPN of the residents' neurological status, range of motion, pain, vital signs and potential injury, bruising, lacerations and fracture.

The clinical record for the resident included documentation by the RPN of the post fall assess however, did not include where the assessment was completed.

The Director of Care (DOC) concurred with the inspector that a physical assessment of the resident was not completed at the location of the fall.

The DOC said that the RPN should have completed an assessment of the resident at the location of the fall.

The DOC further advised that the home's Falls Prevention Post Management policy was not followed and reiterated that the RPN should have completed a physical and neurological assessment of the resident at the location of the fall. [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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with, to be implemented voluntarily.

Issued on this 29th day of July, 2019

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

Original report signed by the inspector.