Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Feb 19, 2021	2021_791739_0005	021951-20, 022632-20, 022755-20	Critical Incident System

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

JULIE DALESSANDRO (739)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 27, 28, 29, and February 1, 2, 3, 4, 5, 9, 10, and 11, 2021

During the course of this inspection the following intakes were inspected:
Log #021951-20/ CI #1149-000036-20 related to responsive behaviours
Log #022632-20/ CI #1149-000040-20 related to an allegation of abuse and neglect
Log #022755-20/ CI #1149-000041-20 related to falls prevention and management

During the course of this inspection the inspector(s) also conducted an infection control inspection.

During the course of the inspection, the inspector(s) spoke with Housekeeper(s), Quality Care Aide(s), Personal Support Worker(s), Registered Practical Nurse(s), Registered Nurse(s), and the home's Unit Managers.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
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 :

The licensee had failed to ensure that the provision of care set out in the plan of care was documented for resident #001, #003, and #004 related to documenting that interventions were in place for safety.

Resident #001 exhibited responsive behaviours. An intervention was in place for safety. A review of resident #001's records in Point Click Care (PCC) indicated that on several dates the documentation related to the safety intervention being in place was not completed.

During an interview with a PSW and a RPN they both stated that resident #001 had a safety intervention in place.

A review of resident #003's records in Point Click Care (PCC) indicated that on several dates the documentation related to the safety intervention being in place was not completed.

A review of resident #004's records in Point Click Care (PCC) indicated that on several dates the documentation related to the safety intervention being in place was not completed.

During an interview with a Unit Manager they stated that resident #001, #003, and #004 did have a safety intervention in place and the expectation was that this was documented by the staff every time it was in place. The Unit Manager acknowledged that there was missing documentation related to the safety intervention being in place for all three residents.

There was a minimal risk to resident's due to the fact that documentation was missed.

Sources: Progress notes in PCC, Documentation Summary Report V2 in PCC, and staff interviews.

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 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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee had failed to ensure that a resident's impaired skin integrity was assessed weekly by a member of the registered staff.

O. Reg. 79/10, s. 50 (3) states in part that altered skin integrity is defined as, "potential or actual disruption of the epidermal or dermal tissue".

A progress note in Point Click Care (PCC) stated in part that, the resident had an area of altered skin integrity. Another progress note on the same day indicated that the area of altered skin integrity had become larger. There were no further documented assessments of the area.

During an interview with a Registered Practical Nurse (RPN), they stated that they assessed the resident and they did have an area of altered skin integrity. The RPN also stated that they documented the measurements of the area in the progress notes in PCC but did not continue to document on the area weekly thereafter. The RPN acknowledged that weekly assessments were not completed.

During an interview with a Unit Manager, they acknowledged that the resident should have had weekly assessments completed for their altered skin integrity and confirmed that the assessments were not completed and documented in PCC.

There was a potential risk of harm to the resident due to the fact that weekly assessments were missed.

Sources: Progress notes, treatment observation record, weekly wound assessments, head to toe assessments, and staff interviews

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 impaired skin integrity is assessed weekly by a member of the registered staff, to be implemented voluntarily.

Issued on this 19th day of February, 2021

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

Original report signed by the inspector.