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_0004	021809-20, 021874-20, 022730-20	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

JULIE DALESSANDRO (739), ALICIA MARLATT (590)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

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

During the course of this inspection the following intakes were inspected:
Log #021809-20 related to staffing and continence
Log #021874-20 related to resident's rights
Log #022730-20 related to nutrition, falls, medication, and personal support services

During the course of the inspection, the inspector(s) spoke with Quality Care Aide (s), Housekeeping, Personal Support Worker(s), Registered Practical Nurse(s), Registered Nurse(s), the home's Director of Programs and Support Services, Clinical Service's Manager, Unit Manager, Director of Care, and Administrator as well as resident's and their Substitute Decision Makers.

During the course of this inspection the inspector(s) also conducted record reviews and observations relevant to this inspection

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services

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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee had failed to ensure that resident #001, #006, and #007 were bathed, at a minimum, twice a week

A complaint was received from the Substitute Decision Maker (SDM) for resident #001 who was concerned that the resident was not being bathed regularly.

A review of bathing records for a two month period for resident #001 showed that on several occasions they were documented as not available for bathing. A record review of the corresponding progress notes in Point Click Care (PCC) on the identified days showed that the resident was available and, in the facility, and there was no evidence to support that the resident had refused baths.

A review of bathing records for a two month period for resident #006 showed that on several occasions they were documented as not available. A record review of the corresponding progress notes in PCC on the identified days showed that the resident was available and, in the facility, and there was no evidence to support that the resident had refused baths.

A review of bathing records for a two month period for resident #007 showed that on several occasions they were documented as not available and on one occasion there was no documentation present. A record review of the corresponding progress notes in PCC on the identified days showed that the resident was available and, in the facility, and there was no evidence to support that the resident had refused baths.

The home's Administrator stated that when the staff documented ‘not available’ that indicated that the resident was not available, physically, to have been bathed and acknowledged that resident #001, #006, and #007 had missed baths.

There was a minimal risk of harm due to the resident’s missing their baths on the specified dates.

Sources: Resident #001's, 006's, and 007's Point of Care bathing records, PCC progress notes, as well as the Long Term-Care Home’s policy related to Hygiene, Personal Care and Grooming, and interviews with the Administrator and other staff.

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 resident's are bathed, at a minimum, twice a week, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 137. Restraining by administration of drug, etc., under common law duty

Specifically failed to comply with the following:

s. 137. (2) Every licensee shall ensure that every administration of a drug to restrain a resident when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in section 36 of the Act is documented, and without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. Circumstances precipitating the administration of the drug. O. Reg. 79/10, s. 137 (2).
2. Who made the order, what drug was administered, the dosage given, by what means the drug was administered, the time or times when the drug was administered and who administered the drug. O. Reg. 79/10, s. 137 (2).
3. The resident's response to the drug. O. Reg. 79/10, s. 137 (2).
4. All assessments, reassessments and monitoring of the resident. O. Reg. 79/10, s. 137 (2).
5. Discussions with the resident or, where the resident is incapable, the resident's substitute decision-maker, following the administration of the drug to explain the reasons for the use of the drug. O. Reg. 79/10, s. 137 (2).

Findings/Faits saillants :

The licensee had failed to ensure that a discussion with a resident's Substitute Decision Maker (SDM) was documented explaining the reason for use of a certain medication after it had been administered to the resident to prevent harm to themselves and others.

A complaint was received from the SDM for a resident who was concerned that the resident was administered a certain medication without their knowledge.

A record review of the resident's progress notes in Point Click Care (PCC) indicated that they were exhibiting behaviours. One of the home's physician's was called and an order was received to administer a certain medication. There was no documentation in the resident's clinical chart to support that the resident's SDM had been notified of the administration of this medication.

During an interview with a Registered Nurse (RN), they stated that they were the Nurse working that day and they administered the medication to the resident. The RN stated that they did not call the resident's SDM to inform them that the medication had been administered.

During an interview with the home's Director of Care (DOC), they stated that the expectation was that the SDM would have been called after the certain medication was administered. The DOC reviewed the progress notes and acknowledged that there was no documentation related to a discussion having been had with the resident's SDM explaining the reason for use of the medication after it had been administered to the resident.

There was minimal risk of harm to the resident due to the fact that their SDM was not notified of the reason the certain medication was administered.

Sources: Progress notes, medication administration record, prescriber's digiorder form, 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 discussions with the resident or, where the resident is incapable, the resident's substitute decision-maker, following the administration of a chemically restraining drug to explain the reasons for the use of the drug., to be implemented voluntarily.

Issued on this 19th day of February, 2021

[redacted]

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

Original report signed by the inspector.