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
Oct 6, 2021	2021_791739_0038	008795-21	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), MEAGAN MCGREGOR (721)

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): September 28 and 29, 2021.

During the course of this inspection the following intake related to falls management was inspected:
Log #008795-21/CI #1149-000004-21

During the course of the inspection, the inspector(s) spoke with a resident, a Housekeeper, Personal Support Workers, Registered Practical Nurses, and the Director of Clinical Services.
During the course of this inspection the inspector(s) also conducted observations and record review relevant to the inspection. The inspector(s) also conducted an infection control inspection during this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain

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. 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 :

The licensee had failed to ensure that procedures included in the Falls Prevention and Management Program were complied with. Specifically, the staff did not comply with post-fall procedures for a resident.

O.Reg. 79/10 s.48(1) requires a fall prevention program to reduce the incidence of falls and the risk of injury.

The home’s fall prevention and management program stated in part that, a Personal Support Worker (PSW) finding a resident following a fall would take specific action as outlined in the program.

A progress note in Point Click Care (PCC) indicated that the resident had a witnessed fall.

During an interview with the resident, PSW #100 and RPN #101 they all stated that PSW #106 had not followed the home’s fall prevention and management program after the resident had fallen.

During an interview with the Director of Clinical Services they acknowledged that PSW #106 did not follow the home’s fall program when a resident had fallen.

Not following the home's Fall Prevention and Management program resulted in harm to the resident.

Sources: The home’s Fall Prevention and Management Program, progress notes from PCC, resident and staff interviews. [s. 8. (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 procedures included in the Falls Prevention and Management Program are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee had failed to ensure that PSW #106 used safe transferring techniques when assisting a resident.

A progress note in Point Click Care (PCC) indicated that the resident had a witnessed fall. The resident had been able to report on the fall and stated that they had not been transferred safely.

Record review of the resident's assessment and care plan in PCC indicated that they required specific assistance when transferring.

During an interview with the resident they stated that PSW #106 had not provided them with the assistance they required which caused them to fall.

During an interview with PSW #100 they stated that, PSW #106 had told them that they had not provided the resident with the assistance needed during a transfer which caused the resident to fall.

During an interview with the Director of Clinical Services they acknowledged that PSW #106 did not use safe transferring techniques when assisting resident #001.

Not using safe transferring techniques resulted in harm to the resident.

Sources: Progress notes from PCC, safe ambulation lift and transfer assessment, plan of care, as well as resident 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 staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

Issued on this 6th day of October, 2021

[redacted]

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

Original report signed by the inspector.