Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 5, 2014	2014_257518_0026	L-000571-14	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

ALISON FALKINGHAM (518)

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): May 30, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Registered Nurse Unit Manager, a residents family member, a Registered Practical Nurse and four Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed a residents clinical record, reviewed the homes policies regarding residents personal aids and equipment and communication, observed general and specific resident care.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Findings of Non-Compliance were found during this inspection.

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	Legendé 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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

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

A resident was observed with their personal adaptive equipment not secured properly. A staff member came into the room and confirmed that the personal equipment was improperly placed.

A staff member on duty confirmed the directions on the care plan were not followed.

The Director of Care confirmed that the expectation is that directions set out in the plan of care are to be followed. [s. 6. (7)]

2. The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the residents plan of care.

The directions for proper use of personal adaptive devices were outlined in the plan of care.

Three out of four staff members interviewed were not aware of this information.

The Unit Manger confirmed it is an expectation that all staff be aware of and follow the residents kardex and care plan. [s. 6. (8)]

Issued on this 10th day of June, 2014

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