



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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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2018	2018_573581_0011	027302-18	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON
L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Ridgeview
385 Highland Road West STONEY CREEK ON L8J 3X9

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

DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): October 17, 18 and 19, 2018.

During the course of the inspection, the inspector reviewed the plan of care, observed the resident, reviewed investigation notes, policies and procedures and any other relevant documents.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN) and Registered Practical Nurses (RPN), Personal Support Workers (PSW), family member and resident.

**The following Inspection Protocols were used during this inspection:
Falls Prevention**

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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).

Findings/Faits saillants :



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

A review of Critical Incident Report (CIR) intake #027302-18, 2849-000017-18, submitted on an identified day in October 2018, identified that Personal Support Worker (PSW) #106 failed to assist resident #001 when they were unsteady while performing a specific care intervention with a specific device and the resident fell.

A review of the written plan of care at the time of the fall identified the resident had a specific assistance level and usually used a device to ambulate with an identified number of staff.

On an identified day in October 2018, it was documented in the progress notes that resident #001 had a fall when they were performing a specific care intervention and sustained an injury. The resident was sent to hospital for further assessment and was diagnosed with multiple injuries.

Review of the video footage of the fall identified that PSW #106 did not notice that the resident was experiencing difficulties while performing a specific care intervention and did not provide the specified assistance for the resident.

It was confirmed in an interview with the Director of Care (DOC) on an identified day in October 2018, that resident #001 was not provided the identified assistance level from PSW #106 when performing a specific care intervention with a device which resulted in the resident falling.

The care set out in the plan of care was not provided to resident #001 as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.



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Issued on this 26th day of November, 2018

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

Original report signed by the inspector.