Ontario

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 27, 2019	2019_791739_0025	016227-19	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

Riverside Place
3181 Meadowbrook Lane WINDSOR ON N8T 0A4

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): August 21, 22, 23, and 26, 2019

Log #016227-19 / CI #2972-000006-19 related to the unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with Personal Support Worker(s), Registered Practical Nurse(s), Registered Nurse(s), the home's Assistant Director of Care, Director of Care, and Executive Director.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

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 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Critical Incident System (CIS) report #2972-000006-19 was submitted to the Ministry of Health and Long-Term Care on a specific date. The CIS identified that resident #001 was involved in a significant medical event.

Record review of resident #001's care plan in Point Click Care (PCC), indicated that they exhibited responsive behaviours and should have been checked frequently for safety.

Record review of a binder with resident #001's name on it contained documents which indicated that the safety checks were to be completed at a different time interval than resident #001's care plan specified.

During interviews with Personal Support Worker (PSW) #108, and PSW #109, who worked when the significant medical event occurred, they indicated that resident #001 was to be checked frequently for safety and that they did not complete the safety checks on a specific date.

During an interview with PSW #106, who also worked the morning when the significant medical event occurred, they stated that they were not aware that resident #001 was on frequent safety checks and they did not complete the safety checks on a specific date.

Record review of the safety check documentation revealed that several checks were not completed at specific times on a specific date.

During an interview with DOC #101 they stated that the care plan in PCC for resident #001 indicated that safety checks were to be conducted at a different time interval than indicated on the documentation in resident #001's binder. DOC #101 stated that the safety checks should have been done at a specific time interval. DOC #101 acknowledged that the care plan did not set out clear direction for the staff and safety checks were not completed for resident #001 at specific times on a specific date.

The licensee had failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident related to frequency of safety checks. [s. 6. (1) (c)]

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 a written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident., to be implemented voluntarily.

Issued on this 27th day of August, 2019

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

Original report signed by the inspector.