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
Nov 14, 2019	2019_791739_0035	020022-19	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): November 4, 5, and 6, 2019.

The following complaint intake was completed during this inspection:
Log #020022-19 / IL-71213-LO related to a change in condition and pain management.

During the course of the inspection, the inspector(s) spoke with Personal Support Worker(s), Registered Nurse(s), the home's Director of Nursing, as well as the complainant.

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

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

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised when the resident's care needs change.

On a specific date, a complaint was phoned into the Ministry of Long-Term Care INFOline. The complainant stated that resident #001 had not received appropriate care based on their health needs.

A record review of the progress notes from resident #001's clinical chart in Point Click Care (PCC) was conducted and the home's physician #106 documented that resident #001 had a specific medical prognosis.

During an interview with Director of Care (DOC) #104, they stated that a specific medical prognosis indicated that the resident was progressing in their disease process.

During an interview with Registered Nurse (RN) #103, they stated that resident #001 had a change in condition with a specific medical prognosis.

A record review of the home's policy, stated in part that once it had been determined that a resident's care needs had changed, the nurse would have assessed, monitored, evaluated, and documented symptoms at least every four hours. This policy also stated in part that a review of the care plan was required to ensure that goals of care remained consistent with the resident's prognosis.

A record review of resident #001's care plan in PCC indicated that the plan was last updated three months prior to a specific time and it had not been updated to reflect that the resident's care needs had changed.

A record review of progress notes for resident #001 in PCC revealed that documentation had not been completed by the registered staff at the home regarding the resident's condition for the 23 days prior to a specific date. A progress note with a specific date was written by Registered Nurse (RN) #102 and indicated that resident #001 was not in a good condition as observed since the morning. This same progress note also included that resident #001 had been resting in bed until they were found with a significant change in status.

During an interview with RN #102 who had been working when resident #001 had a

significant change in status, they stated that they knew the resident was to be provided with an alternate type of care and noticed that the resident's health status had changed over a period of time up until a specific date, however they had not completed any assessments.

A record review of the weights and vitals tab in PCC for resident #001 indicated that the last documented set of vital signs, which included blood pressure, pulse, respirations, and temperature for resident #001, was last completed 28 days before the resident's significant change in status.

During an interview with DOC #104, they stated that resident #001 had a specific prognosis. DOC #104 stated that the expectation was that the registered staff at the home would have assessed the resident to determine if they needed further intervention.

The licensee had failed to ensure that resident #001's vital signs were reassessed and that their plan of care was revised when the resident's care needs changed. [s. 6. (10) (b)]

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 resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

Issued on this 20th day of November, 2019

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

Original report signed by the inspector.