Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: October 29, 2024
Inspection Number: 2024-1455-0003
Inspection Type: Critical Incident
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: Riverside Place, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 15, 16, 17, 2024

The following intake(s) were inspected:

- Intake: #00123578 -Critical Incident (CI) #2972-000017-24 - relating to falls prevention and management.
- Intake: #00123588 - CI #2972-000018-24 - relating to allegations of improper/incompetent care and treatment.

The following intake(s) were completed:

- Intake: #00127467 - CI #2972-000021-24 - relating to falls prevention and management.
- Intake: #00124767 - CI #2972-000019-24 - relating to infection control.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

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Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure the care plan provided clear direction to staff for a resident.

Rationale and Summary
A resident's care records provided for two different methods of transfer status. The transfer status was documented in three different locations. A progress note which had indicated two different methods, the care plan had provided direction to look at the Safe Lift and Transfer (SALT) assessments which indicated a lesser method of transfer and a logo in the resident's room had provided the same direction as the SALT assessment.

During an interview with a staff member they had indicated that the resident had a specific transfer status. During an interview with the Falls Lead, they indicated that the care plan indicated to use the SALT assessment as it was the most updated information and where the staff would look if they did not know a resident's transfer

status. The resident was observed with the Falls Lead to have had a transfer aid not specified within the SALT assessment. The Falls Lead confirmed the current plan of care provided for unclear direction.

Not ensuring the plan of care provided clear direction to staff posed a risk for the resident to potentially have had inconsistent care and potentially the wrong care.

Sources: Resident's clinical records, observations and staff interviews.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee failed to ensure that care was provided as specified in the plan of care for a resident.

Rationale and Summary
Specific direction was written within a resident's care plan, which were not followed and as a result the resident had sustained an injury.

During an interview with the Director of Care (DOC) they indicated the expectation would have been that staff follow the resident plan of care and had not.

Not ensuring the resident's plan of care was followed provided a risk for the resident to sustain an injury. The direction was not followed and subsequently the resident

was injured.

Sources: Resident's clinical records and staff interview.

WRITTEN NOTIFICATION: Communication and response system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times.

The licensee failed to ensure that a resident had access to the call bell system.

Rationale and Summary
On two separate observations a resident that was capable of using their call bell was observed to have not had access to their call bell.

The Executive Director (ED) had indicated the expectation would have been that all residents would have had access to their call bells and confirmed that the resident was capable of using their call bell.

By not ensuring that the resident had access to the call bell provided for a potential risk of the resident not being able to notify staff when assistance was required.

Sources: Observations and staff interviews