



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
Mar 8, 2019	2019_532590_0008	032653-18, 032915- 18, 000626-19, 004405-19	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

ALICIA MARLATT (590), CASSANDRA TAYLOR (725)

## 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): February 25 - 28 and March 1, 2019.**

**A Follow Up inspection was completed concurrently within this complaint inspection: Intake #000626-18**

**During the course of the inspection, the inspector(s) spoke with the Vice President of Operations and Best Practice Innovations, the Executive Director (ED), the Director of Care (DOC), two Registered Nurses (RN), two Registered Practical Nurses (RPN), one Personal Support Worker (PSW) and one family member.**

**During the course of the inspection, the inspector(s) observed a resident and their room, the provision of resident care, infection prevention and control practices and the posting of required information.**

**During the course of the inspection, the inspector(s) reviewed one residents' clinical record, two employee files, email correspondence, complaint forms and Infoline reports.**

**The following Inspection Protocols were used during this inspection:  
Continence Care and Bowel Management  
Reporting and Complaints  
Responsive Behaviours  
Sufficient Staffing**

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

**2 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 212. (1)	CO #001	2018_747725_0026		590

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>



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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**

**4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure that every resident's right to be properly cared for in a manner consistent with his or her needs were fully respected and promoted.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) pertaining to resident #001 relating to the length of time for a culture specimen to be processed and treatment provided.

During a record review of Point Click Care (PCC), progress notes for resident #001 indicated that on a specific date a specimen was obtained. Further review of the documentation indicated that the results were not received until nine days later, when a staff member phoned to obtain the results as no previous follow-up was noted. Two days after the results were obtained, Nurse Practitioner #108 wrote a prescription for an antibiotic.

During an interview with RPN #103, inspector #725 asked if a specimen was taking a long time to return how one would know to follow up. RPN #103 stated there was no way to know to follow up unless someone inquired or symptoms worsened.

During a record review of PCC, progress notes for resident #001 indicated approximately two months later, that the resident was seen by the physician #109. The physician ordered prophylactic antibiotics but later realized the resident had an allergy on file. The physician then ordered for the pharmacist to complete a review and inquire with the family regarding the reaction type. The pharmacist completed the report the same day the physician saw the resident and ordered antibiotics, and documented in PCC progress notes. No documented follow-up was completed by staff. Resident #001's family called to



inquire six days after the physician's visit. Staff completed a follow up with physician #109 and orders for prophylactic antibiotics were received.

During a record review of PCC progress notes for resident #001 indicated approximately a month later, that family had requested a follow up sample be taken. Documentation in PCC showed that a sample was not obtained until three days after the families request, when the family brought in a specimen bottle.

During an interview with RPN #103 and Clinical Service Manager #107 they both indicated that there was a period of time in February when the home did not have specimen bottles.

During an interview with the Director of Care (DOC) #101, Executive Director (ED) #104 and the Vice President of Operations Best Practice Innovations #100, they acknowledged that the above did not meet the needs of the resident for treatment and diagnosis.

The licensee had failed to fully respect and promote resident #001's right to be properly cared for in a manner consistent with their needs. [s. 3. (1) 4.]

***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 every resident has the right to be properly cared for in a manner consistent with his or her needs, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**



**Specifically failed to comply with the following:**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**

**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**

**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**

**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**

**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**

**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**

**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

A complaint was submitted to the MOHLTC pertaining to resident #001 relating to a list of 11 concerns submitted to the home which had not been processed within 10 days.

During a record review of the homes complaint procedure book on February 28, 2019, from 2018 and 2019 one complaint was found from resident #001's family which was not the list of concerns in question.

During an interview with DOC #101 on February 28, 2019, inspector #725 asked if a complaint had been received from resident #001's family. DOC #101 replied that many complaints had been received and they should be located in the complaint procedure book. Inspector #725 indicated that only one complaint was noted in the book. DOC #101 was asked to provide the complaint documents.

During an interview with the DOC #101, ED #104 and the Vice President of Operations



Best Practice Innovations #100 on February 28, 2019, it was indicated that the home had a complaint procedure. The complaint would go to management, be logged, the appropriate manager would deal with the concerns, all documentation would be logged, all calls to the complainant would be documented on the appropriate sheet and their response, outcome of the investigation, follow up with the complainant and their response. They indicated that this was to be completed within 10 days and forwarded to the MOHLTC if required. Once completed the ED would sign off on the complainant form that it was completed.

The DOC #101 provided an e-mail that was received on a specific date, months prior to this inspection, which indicated the family of resident #001 was "requesting documents again". DOC #101 provided a document dated March 1, 2019 titled APANS Health Services Response and Resolution Form, with a brief summary of the 11 concerns. There was minimal documentation of what was done, no documentation of date and times for follow up with family or family response.

During an interview with ED #104 it was indicated that it appeared as though follow up was not documented and should have been.

The licensee had failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant. [s. 101. (2)]

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**Issued on this 8th day of March, 2019**

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

**Original report signed by the inspector.**