



**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**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de
London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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 26, 2018	2018_563670_0031	006911-18, 010020- 18, 019194-18	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

Riverside Place
3181 Meadowbrook Lane WINDSOR ON N8T 0A4

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

DEBRA CHURCHER (670)

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): November 19, 20, 21 and 22, 2018.

Inspector #731, #739 and #145 were present for this inspection.

**The following intakes were inspected during this inspection;
Log# 010020-18 CIS# 2972-000011-18 related to alleged staff to resident verbal abuse.**

Log# 019194-18 CIS# 2972-000013-18 related to a fall with injury.

Log# 006911-18 CIS# 2972-000008-18 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Director of Care, three Personal Support Workers, one Housekeeping Aide, one Dietary Aide and one Registered Practical Nurse Resident Instrument Coordinator.

During the course of this inspection the inspector observed the overall condition of the home, observed staff to resident interactions, provision of care, reviewed relevant clinical records, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

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

1 WN(s)

0 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 O.Reg 79/10, s. 107. Reports re critical incidents



Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

- 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
- 2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
 - i. a breakdown or failure of the security system,**
 - ii. a breakdown of major equipment or a system in the home,**
 - iii. a loss of essential services, or**
 - iv. flooding.****

O. Reg. 79/10, s. 107 (3).

- 3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
- 4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
- 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

Findings/Faits saillants :



1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital that resulted in a significant change in the resident's health condition.

The home submitted a Critical Incident System Report (CIS) #2972-000013-18 to the Ministry of Health and Long-Term Care on a specific date, regarding an incident that occurred ten days prior to the date the CIS was submitted.

The CIS report stated that resident #003 experienced an incident on a specified date. The home was notified the following day, that resident #003 had been diagnosed with a condition that would require a specific intervention.

During an interview with the Director of Care (DOC) #101 they stated that they were not sure why the report was submitted late and acknowledged that the expectation would be that they would have called the info line if a CIS could not be submitted when the home became aware of the incident and required interventions.

The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital that resulted in a significant change in the resident's health condition. [s. 107. (3)]

Issued on this 26th day of November, 2018

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



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Original report signed by the inspector.