Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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 10, 2020	2020_791739_0026	014609-20, 014678-20	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), DEBRA CHURCHER (670)

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): August 4, 5, 6, and 7, 2020.

During the course of this inspection the following intakes were inspected related to falls:
Log #014678 / CI #2972-000011-20
Log #014609 / IL-80395-LO

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

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

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 resident #001 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

On a specific date the home submitted a Critical Incident Report to the Ministry of Long-Term Care which indicated that resident #001 had a fall. Resident #001 was lying on their side and was having a lot of pain in their hip. Resident #001 was sent to hospital on the same day.

On a different date a call was made to The Ministry of Long-Term Care INFOline, IL-80395-LO. Complainant stated that resident #001 had a significant change in status and they were concerned with the information about the fall . Complainant also stated that resident #001 had altered skin integrity and they had not been informed of this.

Review of resident #001's clinical record showed that they had sustained a fall with injury on a specific date and were admitted to hospital. Resident #001 had a significant change in status on a specific date after the fall.

Review of resident #001's clinical record showed that they had a Fall Risk Assessment completed on a specific date, indicating that they were a high fall risk.

Review of resident #001's plan of care showed an entry under the falls focus, on a specific date, that stated the resident had been screened as a medium fall risk.

Review of resident #001's plan of care showed an entry under the falls focus, on a specific date after the significant change in status, that stated the resident had been screened as a high fall risk.

During an interview with Associate Director of Care (ADOC) #103, the date of the significant change in status, as well as assessments and plan of care entries were reviewed. ADOC #103 acknowledged that the plan of care was not revised when resident #001 was identified as a high fall risk and it should have been. ADOC #103 could not offer an explanation as to why the plan of care had been updated after the significant change in status.

The licensee had failed to ensure that resident #001 was reassessed and the plan of

care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [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 ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan. O. Reg. 79/10, s. 24 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan. O. Reg. 79/10, s. 24 (5).

Resident #001 was admitted to the Long-Term Care Home on a specific date. An admission progress note in Point Click Care (PCC) dated the same day the resident was admitted indicated that upon admission the resident's skin condition was dry.

A record review of progress notes in resident #001's clinical chart in PCC on a specific date approximately four months later, written by the resident's physician, noted that the resident appeared to have had altered skin integrity and they were prescribing a treatment. There was no documentation in PCC to indicate that the physician or registered staff had informed the substitute decision maker of the altered skin integrity or the new treatment order.

Record review of resident #001's digital prescribers order sheet, in their paper chart, had the treatment order as prescribed by the physician. The order indicated that the medication and treatment record had been updated however it did not indicate that consent was received from the substitute decision maker.

During an interview with ADOC #103 they stated that the expectation would have been that the substitute decision maker was made aware of the new order and this should have been documented in resident #001's progress notes or on the digital prescribers order sheet.

ADOC #103 acknowledged that resident #001's substitute decision-maker was not made aware of the new order and had not been given an opportunity to participate in the revision of the care plan. [s. 24. (5)]

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 the resident's substitute decision-maker and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan., to be implemented voluntarily.

Issued on this 10th day of August, 2020

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

Original report signed by the inspector.