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
Dec 3, 2020	2020_791739_0039	018380-20, 022103-20	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)

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 16,17,18,19,20,23,24 and 25, 2020

During the course of this Complaint Inspection the following intakes were inspected:
Log #018380 related to responsive behaviours and medication management
Log #022103 related to insufficient staffing leading to resident's acquiring skin breakdown

During the course of the inspection, the inspector(s) spoke with Personal Support Worker(s), Registered Practical Nurse(s), Registered Nurse(s), The Home's Assistant Director of Care, Director of Care, and Executive Director as well as the complainant.

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

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee had failed to ensure that medication was administered to a resident in accordance with the directions for use specified by the prescriber.

A resident was prescribed a medication for responsive behaviours. The resident's Substitute Decision Maker (SDM) stated that the resident missed several doses of this medication.

A record review of the resident's medication count sheet indicated that the medication was unavailable for nine days. A Registered Practical Nurse (RPN) stated that, although they did not give the medication on their shift, they called the resident's SDM when they noticed the medication was empty.

The resident's Medication Administration Record in Point Click Care indicated that the resident missed several doses of medication because it was unavailable. The home's DOC acknowledged that the resident was not given the medication as ordered by the physician. Due to the resident missing several doses of medication there was a potential risk for harm.

Sources: The resident's medication administration record, progress notes, and medication count sheet as well as an interview with the complainant, RPN, and the home's DOC.

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 medication is administered to a resident in accordance with the directions for use specified by the prescriber., to be implemented voluntarily.

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Issued on this 3rd day of December, 2020

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

Original report signed by the inspector.