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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 27, 2021	2021_563670_0005	024254-20, 024255-20, 024256-20, 024257-20	Follow up

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), JULIE DALESSANDRO (739)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 20, 21 and 22, 2021

The purpose of this inspection was to inspect the following;
Log #024254-20 Follow up related to weekly wound assessments.
Log #024255-20 Follow up related to Infection Control and Prevention team and quarterly meetings.
Log #024257-20 Follow up related to monitoring suspected or confirmed infections every shift.
Log #024256-20 Follow up related to Infection Prevention and Control required analysis.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurse Infection Prevention and Control Lead, one Housekeeper, two Registered Practical Nurses, one Registered Nurse and multiple residents.

During the course of this inspection the Inspectors observed the overall maintenance and cleanliness of the home, observed staff to resident interactions, observed the provision of care, reviewed relevant resident records and reviewed relevant internal documentation.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
1 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 # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (2)	CO #002	2020_563670_0034	739
O.Reg 79/10 s. 229. (6)	CO #004	2020_563670_0034	670
O.Reg 79/10 s. 50. (2)	CO #001	2020_563670_0034	739

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

The licensee has failed to ensure that on every shift, resident #004, #005 and #006 had their symptoms indicating the presence of infection monitored in accordance with evidence-based practices.

A) Review of resident #004's clinical record showed a Physician Nurse Practitioner note that stated resident #004 had been experiencing specific symptoms for two days.

Physician Nurse Practitioner note for resident #004, dated two days after the previous progress note stated that resident #004 continued to experience the specific symptoms.

The inspector was unable to locate, and the home was unable to provide any documentation related to monitoring of symptoms for seven shifts while resident #004 was experiencing specific symptoms.

B) Review of resident #005's clinical record showed a Physician Nurse Practitioner note dated for a specific date that stated resident #005 had a specific diagnosis and treatment for the specific diagnosis was ordered.

The Inspector was unable to locate, and the home was unable to provide any documentation related to monitoring of symptoms for three shifts while resident #005 had the specific diagnosis.

C) Review of resident #006's clinical record showed a progress note that showed that resident #006 had a specific condition.

The Inspector was unable to locate any monitoring of symptoms for one shift.

During an interview on April 21, 2021, the Inspector reviewed the clinical records of resident #004, #005 and #006 with Registerd Nurse Infection Prevention and Control Lead (RNIPACL) #102 who acknowledged that all three residents did not receive and have documented, every shift symptom monitoring of of a suspected or confirmed condition. RNIPACL #102 confirmed that it was the expectation that any resident with a specific suspected or confirmed condition should be monitored for symptoms every shift and this should be documented in the progress notes.

The homes failure to monitor and record symptoms of a specific condition in residents on every shift placed resident #004, #005 and #006 at risk of complications.

Sources: Resident #004, #005 and #006's clinical records and interview with RNIPACL #102.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 28th day of April, 2021

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DEBRA CHURCHER (670), JULIE DALESSANDRO (739)

Inspection No. / No de l'inspection : 2021_563670_0005

Log No. / No de registre : 024254-20, 024255-20, 024256-20, 024257-20

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Apr 27, 2021

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

LTC Home / Foyer de SLD : Riverside Place
3181 Meadowbrook Lane, Windsor, ON, N8T-0A4

Name of Administrator / Nom de l'administratrice ou de l'administrateur : David Towers

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To AXR Operating (National) LP, by its general partners, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2020_563670_0034, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with O. Reg. s. 229. (5) (b)

Specifically the licensee shall:
-Ensure that any resident that is experiencing or is suspected of having an infection is monitored for signs and symptoms every shift.
-Ensure that any monitoring is documented in one consistent location that is accessible to anyone that may require it.

Grounds / Motifs :

1. The licensee has failed to ensure that on every shift, resident #004, #005 and #006 had their symptoms indicating the presence of infection monitored in accordance with evidence-based practices.

A) Review of resident #004's clinical record showed a Physician Nurse Practitioner note that stated resident #004 had been experiencing specific symptoms for two days.

Physician Nurse Practitioner note for resident #004, dated two days after the previous progress note stated that resident #004 continued to experience the specific symptoms.

The inspector was unable to locate, and the home was unable to provide any

documentation related to monitoring of symptoms for seven shifts while resident #004 was experiencing specific symptoms.

B) Review of resident #005's clinical record showed a Physician Nurse Practitioner note dated for a specific date that stated resident #005 had a specific diagnosis and treatment for the specific diagnosis was ordered.

The Inspector was unable to locate, and the home was unable to provide any documentation related to monitoring of symptoms for three shifts while resident #005 had the specific diagnosis.

C) Review of resident #006's clinical record showed a progress note that showed that resident #006 had a specific condition.

The Inspector was unable to locate any monitoring of symptoms for one shift.

During an interview on April 21, 2021, the Inspector reviewed the clinical records of resident #004, #005 and #006 with Registerd Nurse Infection Prevention and Control Lead (RNIPACL) #102 who acknowledged that all three residents did not receive and have documented, every shift symptom monitoring of of a suspected or confirmed condition. RNIPACL #102 confirmed that it was the expectation that any resident with a specific suspected or confirmed condition should be monitored for symptoms every shift and this should be documented in the progress notes.

The homes failure to monitor and record symptoms of a specific condition in residents on every shift placed resident #004, #005 and #006 at risk of complications.

Sources: Resident #004, #005 and #006's clinical records and interview with RNIPACL #102.

Severity: The home did not monitor and record symptoms of a specific condition in residents on every shift resulting in minimal harm and minimal risk to resident #004, #005 and #006.

Scope: This issue was widespread as the home did not monitor and record symptoms of a specific condition every shift for residents #004, #005 and #006.

Compliance History: 15 Written Notifications, 11 Voluntary Plans of Correction, and three Compliance Orders related to different subsections of the legislation were issued to the home in the last 36 months. One Written Notification and one Compliance Order was issued to the home related to the same subsection of the legislation in the last 36 months. (670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 17, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of April, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Debra Churcher

Service Area Office / Bureau régional de services : London Service Area Office