Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
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Original Public Report

Report Issue Date: August 4, 2023	
Inspection Number: 2023-1455-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: AXR Operating (National) LP, by its general partners	
Long Term Care Home and City: Riverside Place, Windsor	
Lead Inspector Adriana Congi (000751)	**Inspector Digital Signature** Adriana Congi Digitally signed by Adriana Congi Date: 2023.08.08 08:47:04 -04'00'
Additional Inspector(s) Julie DAlessandro (739)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 31 and August 1 and 3, 2023

The following intakes were inspected:

- Intake: #00087636 related to falls prevention and management; and
- Intake: #00090940 related to pain management, resident care and support services, and palliative care

The following intakes were completed in this inspection: Intake #00021678 and Intake #00022893 were related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Palliative Care
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care not revised

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident's plan of care was revised when a diet order was changed.

An order was written by a registered staff indicating a change in diet status. This order was signed off by the physician.

A review of the resident's plan of care was completed and had not been updated with the new diet status.

During staff interviews it was indicated that the expectation would have been that the plan of care was updated to include the change in diet. The Director of Care (DOC) acknowledged that the plan of care had not been updated.

The plan of care not being revised posed a risk to the resident.

Sources: Progress notes, digiorder form, plan of care, and staff interviews with registered staff and DOC. [739]