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
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: October 22, 2024
Inspection Number: 2024-1455-0004
Inspection Type: Proactive Compliance Inspection
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: Riverside Place, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 15, 16, 17, 18, 2024
The following intake(s) were inspected:

- Intake: #00128921 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards

Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provide direct care to the resident.

During an observation of a resident the inspector noted a sign for specific interventions.

A review of the resident's plan of care was conducted and no direction related to the specific interventions could be located.

During an interview with a staff member, they indicated that the resident had a condition that required additional interventions, and this should have been part of

the resident's plan of care. The staff member immediately updated the plan of care to reflect the need for additional interventions.

Date Remedy Implemented: October 17, 2024

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