



**Ministry of Health and
Long-Term Care**

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

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Bureau régional de services de
London
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2015	2015_264609_0008	000869-15	Critical Incident System

Licensee/Titulaire de permis

S & R NURSING HOMES LTD.
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

Long-Term Care Home/Foyer de soins de longue durée
AFTON PARK PLACE LONG TERM CARE COMMUNITY
1200 AFTON DRIVE SARNIA ON N7S 6L6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs
CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 17-18, 2015

During the course of the inspection, the inspector(s) spoke with 2 Registered Practical Nurses, 1 Registered Nurse, 2 Personal Support Workers, 1 Administrator, 1 Assistant Manager of Resident Care, 1 Resident Care Coordinator, 1 Manager of Resident Care and 1 Resident.

During the course of the inspection, the inspector reviewed clinical records, required program minutes, and policies and procedures of the home. The inspector also observed residents and resident care being performed.

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

During the course of this inspection, Non-Compliances were issued.

**1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)**



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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

Legendé

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).

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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**



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Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :



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1. The licensee has failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to a resident.

The timing of safety checks in the plan of care and the actual timing of safety checks by staff for an identified resident did not correspond.

The Assistant Manager of Resident Care acknowledged the discrepancy between staff expectation for care and the plan of care related to timing of safety checks for an identified resident.

The Assistant Manager of Resident Care confirmed that it is the home's expectation that the plan of care should have provided clear direction to staff and in the case of an identified resident this did not occur. [s. 6. (1) (c)]

2. The licensee has failed to ensure that when the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care.

Clinical record review demonstrated that for an identified resident a fall risk intervention was discontinued and that other approaches were not considered in the revision of the plan of care.

Confirmed with the Assistant Manager of Resident Care that other approaches should have been considered and for an identified resident it did not occur. [s. 6. (11) (b)]

Issued on this 19th day of February, 2015

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



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Original report signed by the inspector.