Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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 9, 2019	2019_538144_0055	022367-19	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

Long-Term Care Home/Foyer de soins de longue durée

Banwell Gardens Care Centre
3000 Banwell Road TECUMSEH ON N8N 2M4

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

CAROLEE MILLINER (144)

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): December 5, 2019.

The following intakes was inspected within this inspection:
Log 022367-19, IL-72288-LO related to plan of care and skin and wound.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care and two Registered Nurses.

During the course of the inspection, the inspector observed one resident room and one resident clinical record.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Skin and Wound Care

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)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of one resident were fully respected and promoted related to participating fully in making any decision concerning any aspect of their care.

The Power of Attorney (POA) for one resident shared with the inspector that they were contacted by telephone by Registered Nurse (RN) #103 who advised them that an appointment was being made for the resident to be assessed for a suspected health condition.

The POA said they researched the condition on line, then contacted RN t#103 to advise that the resident be assessed at the hospital on that same date.

The POA shared that RN #013 told them that the resident was fine at that time, the resident was not sick enough to be assessed at the hospital and that the hospital would transfer the resident back to the home on the same date.

The inspector reviewed the clinical record for the resident for the date of concern. The

record reveled the residents' vital signs were within normal range.

At a later date, the physician for the resident documented in the clinical record their suspicion that the resident may have the health condition RN #103 spoke with the POA about.

The resident was transferred to hospital for assessment and returned to the home on the same date.

The hospital contacted the home after the resident was returned, to report the diagnosis that the physician suspected.

The following day, the resident was admitted to the hospital.

RN #102 confirmed with the inspector that the POA remained concerned that the resident was not assessed at their request.

RN #103 confirmed with the inspector, the telephone conversation with the POA and, said they did not want resident the resident to sit in the hospital for hours only to be transferred back to the home.

Executive Director #100 and Director of Care #101 shared that the resident should have been transferred to the hospital at the request of the POA.

The licensee failed to ensure that the rights of resident #001 were fully respected and promoted related to participating fully in making any decision concerning any aspect of their care. [s. 3. (1) 11. iii.]

Issued on this 9th day of December, 2019

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

Original report signed by the inspector.