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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 10, 2013	2013_049143_0056	O-000946-13	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (WARKWORTH)
97 Mill Street, P.O. Box 68, Warkworth, ON, K0K-3K0

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

PAUL MILLER (143)

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): November 14th, 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, the Program Director, residents and a family member.

During the course of the inspection, the inspector(s) reviewed a resident's health care record inclusive of plan of care, assessments, physician orders, medication administration records, resident activity attendance records; observed resident care and services and resident/staff interactions as well as family and resident interactions.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Medication

Personal Support Services

Recreation and Social Activities

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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.) 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:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On a specified date the long-term care home received a copy of a letter addressed to the complainant from Resident #1's Power of Attorney (POA), Lawyer. This letter advised the complainant that she/he was prohibited from visiting resident #1.

The Administrator reported to the inspector that she sought out legal advice from her corporate office as well as the Advocacy Centre for the Elderly (ACE). The Administrator reported that she reviewed guiding principles provided from ACE with Resident #1's POAs. The guiding principles discussed with the POAs indicated that the denial of access between an incapable older adult and his or her supportive friends and family members is harmful and goes against the principles of a Substitute Decision Maker.

On a specified date following discussions with Resident #1 POAs, the complainant was permitted to resume visits. On a specified date the resident's POAs addressed a letter to the complainant indicating that the complainant could take Resident #1 out in the community. Conditions within this letter indicated that the complainant was limited to 1 1/2 hours visits in the community and must have someone else capable of helping in an emergency situation. The conditions also indicated that complainant will be responsible for Resident #1 safety and if these outings caused any adverse effects to the resident than community outings would not be permitted.
Resident #1 was interviewed on November 14th, 2013 by the inspector. Resident #1 reported that she/he looks forward to her/his community outings and indicated that 1 1/2 hours did not give her/him enough time to visit and enjoy herself/himself. The Administrator reported to the inspector that she has not observed the complainant be abusive towards Resident #1 and is not aware of any safety concerns in the community while Resident #1 is out with the complainant. The Administrator reports that the complainant is one of the primary visitors for resident #1.

The licensee has failed to comply with the Long-term care homes Act section.(1) 14 by not fully respecting Resident #1's right to receive visitors of her choice and consult in private without interference. [s. 3. (1) 14.]

Issued on this 10th day of December, 2013

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