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
Mar 12, 2013	2013_128138_0013	O-000118-13	Complaint

Licensee/Titulaire de permis

KEAY NURSING HOMES INC
10-112 Red Pine Road, P.O. Box 21, GRAND BEND, ON, N0M-1Z0

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

E. J. MCQUIGGE LODGE
38 Black Diamond Road, P.O. Box 68, Cannifton, ON, K0K-1K0

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

PAULA MACDONALD (138)

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): March 8, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Practical Nurse, Registered Dietitian, a resident, and a resident's family member.

During the course of the inspection, the inspector(s) observed several residents, observed a resident at a meal service, and reviewed a resident's health record.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

Personal Support Services

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, 6. (5) in that the licensee failed to ensure that the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident was confirmed by the health care record to have a specific diet order. The health care record also demonstrated that the resident's family wished to make changes to this diet order but the family felt that their wishes with respect to the diet order were not respected by the home.

The resident's health care record was reviewed and it was noted that the physician entered a note stating that the family was aware of the resident's health risks related to changing the resident's diet order. The physician further wrote that the family's wishes would be followed as they accept the risks and are aware that it was made clear this would not be recommended but that their wishes will be respected. A physician's order was also written confirming that the resident's change in diet order.

The following week the physician entered another note stating that the family made voluntarily changes to the residents diet order until a medical test was conducted. A corresponding progress note demonstrated that the resident's interdisciplinary care team supported this decision.

However, about two weeks later, an entry was made in the resident's progress notes that stated that the resident's family member made a dietary request that was not consistent with the decision referred to earlier. At this time, the family was requested by the home to sign a release of responsibility form for providing the resident with care that was against medical advice. The resident's family did not sign the form.

Later that same day, there was another progress note that stated that actions were taken by the home because the family refused to sign a release of responsibility.

On another day, a progress note stated that the RPN intervened against the resident's husband wishes in providing nutritional care to the resident. [s. 6. (5)]

Issued on this 12th day of March, 2013

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