



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

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

**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**

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

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de
London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Oct 20, 2016	2016_276537_0036	029162-16	Resident Quality Inspection

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE MISSISSAUGA ON L5H 2S6

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

EXETER VILLA
155 JOHN STREET EAST EXETER ON N0M 1S1

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

NANCY SINCLAIR (537), AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 11, 12, 13 and 14, 2016

**The following intake was completed within the RQI:
Log #025684-16/CI 2749-000007-15 regarding the reporting of critical incidents.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Interim Acting Director of Care, Director of Rehab/Activities, Director of Activities/Volunteer Services, two Registered Nurses, one Registered Practical Nurse, two Personal Support Workers, Residents' Council Representative, residents and families.

The inspectors(s) also conducted a tour of resident home areas and common areas, observed residents and care provided to them, medication passes and storage areas, reviewed health care records and plans of care for identified residents, reviewed policies and procedures, meeting minutes and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

**Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
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	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Observation of an identified resident revealed that the resident used a Personal Assistance Service device (PASD). The resident managed the use of the PASD independently and verbalized a desire for the ongoing use of the PASD. There was a care plan in place that identified the use of the PASD.

Interview with Registered Nurse #101 stated the PASD was used as per the resident interview and the written plan of care.

The Resident Assessment Protocol (RAP) identified the use of the PASD as a restraint.

Interview with the Interim Director of Care #100 stated that it was the expectation that the RAP assessment would be consistent with and complement the plan of care for the resident. [s. 6. (4) (a)]



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Issued on this 20th day of October, 2016

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

Original report signed by the inspector.