



**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**

**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  
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## Public Copy/Copie du public

<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Nov 10, 2015	2015_260521_0048	021410-15	Complaint

### Licensee/Titulaire de permis

GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC  
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

GOLDEN YEARS NURSING HOME  
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

REBECCA DEWITTE (521)

## Inspection Summary/Résumé de l'inspection



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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): October 26, 27, 2015.**

**This inspection was completed concurrently with inspection #2015\_260521\_0049 / 008366-15.**

**This complaint was related to resident care and services.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Nurse, a private Registered Nurse, two Residents, the Maintenance worker and the Director of Clinical Services.**

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

**Accommodation Services - Maintenance**

**Dignity, Choice and Privacy**

**Food Quality**

**Medication**

**Safe and Secure Home**

**Skin and Wound Care**

**Sufficient Staffing**

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

**3 WN(s)**

**3 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
- (a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
  - (b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
  - (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**



**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Observations of a resident revealed an independent resident.

A record review revealed the resident became unwell.

The resident continued to feel unwell for numerous days and took to their bed.

An interview with the resident revealed the resident experienced pain for numerous days during the illness.

An interview with the Director of Care confirmed the resident had experienced a change in health status resulting in a change of care needs during the acute onset of an illness. The plan of care did not address the new onset of illness.

The interview confirmed the resident was not reassessed and the plan of care was not reviewed and revised when the resident's care needs had changed. [s. 6. (10) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**



**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**  
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**  
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

A review of the Resident and Family Handbook revealed the homes protocol regarding purchased services was that “residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers”.

An interview with a resident revealed upon admission to the home both residents had continued to hire a private provider for specific care, until the licensee had placed restrictions.

An interview with the private provider revealed the licensee had met with the private provider and informed them that the People Care contract standards were to be complied with or the private provider would not be allowed in to the home to provide services to the specified residents.

An interview with the People Care administrator from May, 2015, confirmed the meeting did take place and the private provider was told to conform to the People Care contract standards or discontinue the care to residents.

An interview with the current administrator confirmed it was the homes expectation that the resident had a right to purchase care from other providers as stated in the Resident and Family Handbook “residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers”. [s. 8. (1) (b)]



***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan, policy, protocol, procedure, strategy or system that the institute or otherwise have put in place is complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

Observations by the elevator on the second floor revealed medications dispensed into medication cups.

An interview with the Registered Practical Nurse (RPN) revealed the RPN had dispensed the medications into the cups. The RPN confirmed it was the homes expectation that the drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. [s. 126.]



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***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.***

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**Issued on this 10th day of November, 2015**

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

**Original report signed by the inspector.**