Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 6, 2021	2021_729615_0024	008788-21, 008858-21	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

HELENE DESABRAIS (615)

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): July 26, 27, 28 and August 3, 2021.

The following intakes were inspected during this inspection:

Complaint Log #008858-21 related to prevention of abuse, food quality, plan of care, skin and wound, nutrition and hydration;
Complaint Log #008788-21 related to prevention of abuse and plan of care.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the home's Physician, the Director of Care, the Assistant Director of Care - Infection Prevention and Control Lead, the Director Resident Quality Outcomes - Resident Assessment Instrument (RAI), a Registered Nurse, a Registered Practical Nurse, a Personal Support Worker and a resident.

The inspector also toured the home, observed residents and the care provided to them, staff/residents interactions, reviewed residents clinical records, specific home's policies, observed Infection Prevention and Control practices, cooling systems and reviewed other relevant documents.

The following Inspection Protocols were used during this inspection:
Food Quality
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 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 :

The licensee has failed to ensure that a resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A Complaint was submitted to the Ministry of Long-Term Care that alleged the substitute decision-maker (SDM) was not notified when a resident's health conditions deteriorated. The resident's progress notes in Point Click Care (PCC) showed that their health had been declining and, on a specific date, a Registered Practical Nurse (RPN) told a Registered Nurse (RN) that the resident had significant decline in their health. The RN suggested to the RPN that they complete a referral to the physician regarding the resident's decline in health condition and potentially have the physician assess the resident for their needs.

During an interview, the RPN stated that when noticing the resident's health significantly declining they assumed the RN would call the resident's substitute decision-maker but did not. The RPN said that they should of followed-up with the RN about the resident's decline in health condition and the resident's substitute decision-maker should have been contacted at that time but was not.

By not ensuring the resident's substitute decision maker was notified when they had a change in health condition, the SDM was unable to participate in the development and implementation of their plan of care.

Sources: complaint report, resident's progress notes and plan of care, interview with the Executive Director, Assistant Director of Care, a RN and a RPN.

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 a resident's substitute decision-maker, is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 6th day of August, 2021

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

Original report signed by the inspector.