



**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**

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**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Nov 3, 2016	2016_260521_0044	029191-16	Resident Quality Inspection

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**Licensee/Titulaire de permis**

CORPORATION OF THE COUNTY OF GREY  
206 Toronto Street MARKDALE ON N0C 1H0

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

GREY GABLES HOME FOR THE AGED  
206 TORONTO STREET SOUTH MARKDALE ON N0C 1H0

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

REBECCA DEWITTE (521), SHARON PERRY (155)

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**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 27, 28, 31, November 1, 2, 2016.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), two Registered Nurses, three Registered Practical Nurses, one Personal Support Worker (PSW), one Recreational Manager, two Housekeepers, a representative from Residents Council and Family Council, resident's and their families.**

**The inspector(s) also toured the home, observed a medication pass, and reviewed relevant clinical records, meeting minutes, schedules, posting of the required information, observed the provision of resident care and the resident to staff interactions.**

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

**Accommodation Services - Housekeeping  
Contenance Care and Bowel Management  
Infection Prevention and Control  
Medication  
Nutrition and Hydration  
Pain  
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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.



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**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. (7) The licensee shall ensure that the care set out in the plan of care is  
provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. Observations revealed a resident had an odour.

A review of the residents' plan of care revealed the resident's preference was to have one bath per week.

A record review of the baths completed with the resident revealed the resident did not get bathed as per their preference.

An interview with the Director of Care confirmed the resident was not bathed as per their preferences. The DOC also confirmed it was the home's expectation that the care set out in the plan of care should be provided to the resident as specified in the plan. [s. 6. (7)]

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**Issued on this 3rd day of November, 2016**

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

**Original report signed by the inspector.**