Ontario

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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 23, 2016	2016_240506_0004	010059-14	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

NORTHRIDGE
496 POSTRIDGE DRIVE OAKVILLE ON L6H 7A2

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

LESLEY EDWARDS (506)

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 22 and 23, 2016.

Concerns that were identified to be reviewed while at the home were as follows:

Item #1- Resident's Bill of Rights.
Item #2- Plan of Care.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Registered Staff, residents and families.

During the course of the inspection, the inspector toured the home, conducted interviews with the ED, DOC, Registered staff, residents and families, reviewed clinical records, investigation notes and policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

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. (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 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 the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #001 is capable of making their own decisions regarding their care, however had expressed that they prefer their family member to make any decisions regarding any medication changes or immunizations that were to be administered and this was confirmed through clinical record review and interview with the resident on an identified date in March 2016.

i.In the resident's progress notes it identified that the family member wants to be contacted for all new medications and immunizations prior to administration, the nurse agreed and wrote a note in the chart to alert all staff of this request.
ii.On an identified date in December 2014, the nurse called to inform the resident's family member that the resident was showing signs and symptoms of the outbreak. The family member requested that no new medications be given to the resident without speaking to them first.
iii.Later that day, the DOC called the family member to inform them that the resident was experiencing symptoms of the outbreak; again the family member declined treatment and was given the risks associated with not taking the medication.
iv.On an identified date in December 2014, the nurse on duty approached the resident to inform them of the outbreak and about the medication that they could take and the risks and benefits associated with taking the medications. The resident stated "that I will not be taking any medications unless my family member approves."
v.On an identified date in December 2014, the resident was complaining of feeling unwell and the nurse informed the resident that they have an order for the medication that they could have. The resident consented to the medication. The nurse on duty administered the medication prior to informing the family member as previously directed.
The resident and the resident's family members wishes were not followed and they were not given the opportunity to participate fully in the development and the implementation of the resident's plan of care. [s. 6. (5)]

Issued on this 31st day of March, 2016

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

Original report signed by the inspector.