



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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**

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
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**Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité**

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 25, 2014	2014_260521_0033	000225-14	Complaint

Licensee/Titulaire de permis

MACGOWAN NURSING HOMES LTD
719 Josephine Street, P.O. Box 1060, WINGHAM, ON, N0G-2W0

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

BRAEMAR RETIREMENT CENTRE
719 Josephine Street North, R.R. #1, P.O. Box 1060, WINGHAM, ON, N0G-2W0

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

REBECCA DEWITTE (521)

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 15, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care, 2 Registered Nurses, 3 Registered Practical Nurses, 8 Personal Support Workers and 2 family members.

During the course of the inspection, the inspector(s) conducted a tour of resident areas and common areas, observed residents and the care provided to them and reviewed the clinical record of an identified resident.

The following Inspection Protocols were used during this inspection:

- Hospitalization and Change in Condition**
- Infection Prevention and Control**



Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift, (b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :



1. The licensee failed to ensure that on every shift the symptoms are recorded and that immediate action is taken as required as evidenced by;

It was noted that a Resident had unwell symptoms. Medication was administered.

Symptoms were noted.

A Resident was placed in isolation.

A Resident was placed out of isolation.

Symptoms continued as documented for four consecutive days.

A family member expressed concerns for the Resident's health, requesting the Resident be seen by a Doctor.

The Doctor prescribed a treatment for a symptom.

For days after there was no documentation of an assessment of the Resident for this symptom.

Days later the Resident was found to have a change in the symptom and the family reported the Resident had been sleepy for days.

A deterioration in the Resident's condition was noted over a day and night period.

The Resident became unresponsive, was sent to another facility for treatment and later died.

Cause of death indicated an infection.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".



**WN #2: 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 failed to 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 the Resident's care needs change as evidenced by;

A care plan for a Resident was written.

Notes revealed that family were concerned regarding the change in condition of the Resident.

Notes describing the Resident's deteriorating condition were documented.

The Resident continued to deteriorate over the following days and was transferred to another facility for treatment.

The Director of Care confirmed it is the homes expectation to reassess a Resident and revise the care plan when the Resident's care needs change. [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 all residents are reassessed and the care plan is reviewed and revised when a resident's care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the Resident's substitute decision-maker was promptly notified of a serious illness of the Resident as evidenced by;

It was noted at the end of shift that the Resident was more confused.

Another shift documented the Resident was experiencing worsening symptoms.

The Residents substitute decision-maker was not promptly notified of this significant deterioration in health status.

The substitute decision-maker was not notified until the following day when the Resident was transferred to another facility for treatment.

The Resident died.

The Director of Care confirmed it is the homes expectation that substitute decision-makers are promptly notified of a serious illness of any Resident. [s. 107. (5)]



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soins de longue durée

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's substitute decision-maker is promptly notified of a serious illness of a resident, to be implemented voluntarily.

Issued on this 22nd day of August, 2014

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



Ministry of Health and
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Ministère de la Santé et
des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007, S.O. 2007, c.8*

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

**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 performance et de la conformité**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : REBECCA DEWITTE (521)

Inspection No. /

No de l'inspection : 2014_260521_0033

Log No. /

Registre no: 000225-14

Type of Inspection /

Genre

Complaint

d'inspection:

Report Date(s) /

Date(s) du Rapport : Jul 25, 2014

Licensee /

Titulaire de permis :

MACGOWAN NURSING HOMES LTD
719 Josephine Street, P.O. Box 1060, WINGHAM, ON,
N0G-2W0

LTC Home /

Foyer de SLD :

BRAEMAR RETIREMENT CENTRE
719 Josephine Street North, R.R. #1, P.O. Box 1060,
WINGHAM, ON, N0G-2W0

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur :

ARCHIE MACGOWAN

To MACGOWAN NURSING HOMES LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:



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

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

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de soins de longue durée*, L.O. 2007, chap. 8

Order # /

Ordre no : 001

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in
accordance with evidence-based practices and, if there are none, in accordance
with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required.
O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must ensure that on every shift, symptoms indicating the presence
of infection in residents are monitored in accordance with evidence-based
practices and, if there are none, in accordance with prevailing practices; and the
symptoms are recorded and that immediate action is taken as required.

Grounds / Motifs :



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de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee failed to ensure that on every shift the symptoms are recorded and that immediate action is taken as required as evidenced by;

It was noted that a Resident had unwell symptoms. Medication was administered.

Symptoms were noted.

A Resident was placed in isolation.
A Resident was placed out of isolation.

Symptoms continued as documented for four consecutive days.

A family member expressed concerns for the Resident's health, requesting the Resident be seen by a Doctor.

The Doctor prescribed a treatment for a symptom.

For days after there was no documentation of an assessment of the Resident for this symptom.

Days later the Resident was found to have a change in the symptom and the family reported the Resident had been sleepy for days.

A deterioration in the Resident's condition was noted over a day and night period.

The Resident became unresponsive, was sent to another facility for treatment and later died.

Cause of death indicated an infection.

(521)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :** Aug 31, 2014



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

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603



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section 154 of the *Long-Term Care
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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance
Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.



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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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de l'article 154 de la *Loi de 2007 sur les foyers
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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la
conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of July, 2014

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :** Rebecca Dewitte

**Service Area Office /
Bureau régional de services :** London Service Area Office