

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) /

Inspection No / Date(s) du Rapport No de l'inspection

Loa #/ No de registre Type of Inspection / **Genre d'inspection**

Mar 2, 2020

2020 750539 0004 022053-19

Follow up

Licensee/Titulaire de permis

ATK Care Inc. 1386 Indian Grove MISSISSAUGA ON L5H 2S6

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

The Fordwich Village Nursing Home 3063 Adelaide Street Fordwich ON N0G 1V0

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

VALERIE GOLDRUP (539)

Inspection Summary/Résumé de l'inspection



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durée

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 5 and 6, 2020.

The following intake was completed in this inspection:

Log # 022053-19\ Follow-up to Compliance Order (CO) #001 from inspection #2019_755728_0024 regarding Residents' Bill of Rights.

The inspector observed resident care. Clinical records and plans of care for identified residents were reviewed and the home's relevant procedures and policies related to the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Administrative Assistant (AA), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

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)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:



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REQUIREMENT/ EXIGENCE			INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2019_755728_0024	539

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES			
Legend	Légende		
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).	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.		
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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



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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:



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

A) Resident #002's plan of care was reviewed as part of the Follow up inspection. Documents identified that the resident's Power of Attorney for Personal Care (POA-PC) had signed admission paperwork when the resident was admitted to the home.

Review of the resident's documentation indicated four forms were not initialled/signed as per the home's practice to indicate that the POA-PC had reviewed and approved the plan of care.

Resident #002 had a change of condition on two specified dates and the progress notes did not document that the resident's POA-PC had been notified.

B) Resident #005's documents identified that the resident's POA-PC had signed admission paperwork when the resident was admitted to the home.

Review of the resident's documentation indicated two forms were not initialled to indicate that the POA-PC had reviewed and approved the plan of care.

Staff reviewed resident #002 and #005's plan of care and confirmed that the POA-PC should had been contacted, the plan of care reviewed with them and the contact documented.

The home failed to ensure that residents' #002 and #005's substitute decision-maker, if any, and any other persons designated by the resident were given an opportunity to participate fully in the development and implementation of the resident's plan of care.



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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 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, to be implemented voluntarily.

Issued on this 2nd day of March, 2020

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

Original report signed by the inspector.