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

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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 21, 2014	2014_357101_0030	T-330-14	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

MACKENZIE PLACE
52 GEORGE STREET, NEWMARKET, ON, L3Y-4V3

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

AMANDA WILLIAMS (101)

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 17, 2014

Enter any additional information..

During the course of the inspection, the inspector(s) spoke with the Executive Director, the interim Executive Director, the Director of Care, registered nurse, personal support workers, housekeeper,and the Associate Director of Care.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas, observed staff practices related to hand hygiene, reviewed the home's infection prevention and control surveillance and monitoring tools, and observed housekeeping cleaning routines and practices.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents rights are fully respected and promoted in the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

On July 17, 2014, interviews with the Executive Director, Director of Care, Interim Executive Director, and Associate Director of Care confirmed that the home had stopped visitation to residents following 2 consecutive respiratory outbreaks (November 16, 2013- December 11, 2013 and January 9, 2014- February 12, 2014). The home had stopped all visitation to residents with the intent of containing and mitigating the spread of the outbreak for approximately 1 week. It was noted that all residents' Powers of Attorney (POA) were contacted notifying them of such restriction. However, none POAs were not aware of the restriction prior to visitation and were encouraged not to visit unless extenuating circumstances were present. [s. 3. (1) 14.]

Issued on this 21st day of July, 2014

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