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**
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## 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 11, 2014 | 2014_258519_0019 | 001084-14 | Complaint |

**Licensee/Titulaire de permis**

SAUGEEN VALLEY NURSING CENTER LTD
465 DUBLIN STREET, MOUNT FOREST, ON, N0G-2L3

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

SAUGEEN VALLEY NURSING CENTER
465 DUBLIN STREET, MOUNT FOREST, ON, N0G-2L3

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

SHERRI GROULX (519)

### 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 10, 2014**

**During the course of the inspection, the inspector(s) spoke with the Administrator, a Registered Nurse, a Registered Practical Nurse, and three Personal Support Workers.**

**During the course of the inspection, the inspector(s) reviewed the resident's clinical record, the internal incident reports, Policy and Procedure, and other relevant documents. Observations were made of the home's environment and staff interaction with the residents.**

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

**Medication**
**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that every resident has the right to, give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent.

A resident was admitted to Saugeen Valley Nursing Centre.

The resident was admitted to the home on a certain dosage of medications ordered by his/her Doctor.

It was necessary for the staff to call the resident's physician and request a change in his/her medications. An order was received for a change in the dosage and time of the medications.

Upon review of the progress notes there was no entry indicating that the Registered staff contacted the resident's family member to inform them of the medication increase and the change in administration time. Upon review of the Doctor's order sheet there was no indication that the family had been contacted.

Upon interview with staff it was confirmed that a progress note was not written to indicate the family had been contacted of the medication changes. It was also confirmed by the staff that it is the home's expectation that the family is notified of such changes.

Upon interview with the Administrator it was confirmed it is the home's expectation that the staff contact the resident's family when there are any medication changes.

The licensee failed to ensure that the resident's family was able to give or refuse consent to any treatment, care or services for which his or her consent was required by law and to be informed of the consequences of giving or refusing consent. [s. 3. (1) 11. ii.]

**Issued on this 11th day of July, 2014**

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