

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

### Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care Health System Accountability and Performance Division

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé Direction de l'amélioration de la performance et de la conformité London Service Area Office 291 King Street, 4th Floor London ON N6B 1R8

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	Licensee Copy/Copie du Titulai	re Public Copy/Copie Public
Date of inspection/Date de l'inspection December 1, 2010	Inspection No/ d'inspection 2010_105_2926_01Dec094550	Type of Inspection/Genre d'inspection L-01714 Critical Incident
Licensee/Titulaire S&R Nursing Homes Ltd. 265 North Front St. S	Suite 200 Sarnia ON N7T 7X1	
Long-Term Care Home/Foyer de soins de lo St. Andrews Terrace LTC Community 255 St.	ongue durée Andrews St. Cambridge ON N1S 1P	11
Name of Inspector/Nom de l'inspecteur(s) June Osborn #105		
Inspection	Summary/Sommaire d'insp	ection
The purpose of this inspection was to con-	duct a critical incident inspection	related to resident care.
During the course of the inspection, the in- resident.	spector spoke with the administra	ator, DOC, an RPN, and the
During the course of the inspection, the in actions, resident record and the plan of ca		lent, the home's investigation and
The following Inspection Protocols were u Privacy; and Prevention of Abuse, Neglec		s inspection : Dignity, Choice and
Findings of Non-Compliance were	found during this inspection.	The following action was taken:
2 WN 2 CO		



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### NON- COMPLIANCE / (Non-respectés)

### Definitions/Définitions

WN - Written Notifications/Avis écrit

VPC - Voluntary Plan of Correction/Plan de redressement volontaire

DR - Director Referral/Régisseur envoyé

CO - Compliance Order/Ordres de conformité

WAO - Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le Loi de 2007 les foyers de soins de longue durée à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 3(1)1.

Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

### Findings:

1. Resident 1000008 distraught over being catheterized, continued to be held down and was not given the ativan as plan of care stated to assist resident to tolerate procedure.

Inspector ID #:

105

### Additional Required Actions:.

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



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	see has failed to comply with LTC ensure that the care set out in the	HA,2007, S.O. 2007, c.8,s.6(7). plan of care is provided to the resident as specified in
	ates "Administer 2mg of Ativan p e of procedure." Plan of care wa	prior to catheter change as per physician order to as not followed.
Inspector ID #:	105	
Additional Requir	red Actions:	·
CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.		
Signature du Titulaire	e or Representative of Licensee e du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title:	Date:	Date of Report: December 6, 2010



Ministry of Health and Long-Term Care Health System Accountability and Performance Division Performance Improvement and Compliance Branch

### Ministère de la Santé et des Soins de longue durée

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

## 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

Revised for
Publication

	Licensee Copy/Copie du Titulaire	Public Co	py/Copie Public
Name of Inspector:	June Osborn	Inspector ID#	105
Log #:	L-01714		
Inspection Report #:	2010_105_2926_01Dec094550		
Type of Inspection:	Critical Incident		
Date of Inspection:	December 1, 2010		
Licensee:	S&R Nursing Homes Ltd. 265 North Front St. Suite 200 Sarnia ON N7T 7X1		
LTC Home:	St. Andrews Terrace LTC Community		
Name of Administrator:	Mark Van Dyke		

To S&R Nursing Homes Ltd., you are hereby required to comply with the following orders by the dates set out below:

Order #:	001	Order Type:	Compliance Order, Section 153 (1)(a)	
Pursuant to: LTCHA, 2007, S.O. 2007, c.8, s. 3(1)1.  Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:  1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.				
Order: The licensee shall ensure the residents are treated with courtesy and respect in a way that fully recognizes the resident's individuality and respects the resident's dignity.				
Grounds:  1 distraught over being catheterized, continued to be held down and was not given the ativan as plan of care stated to assist resident to tolerate procedure.				
This order r	nust be complied w	<b>/ith by</b> : Decen	nber 9, 2010	



### Ministry of Health and Long-Term Care

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée

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

Order #: 002 Order Type: Compliance Order, Section 153 (1)(a)

Pursuant to: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(7).

The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

### Order:

The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

### **Grounds:**

1. Plan of care states "Administer 2mg of Ativan prior to catheter change as per physician order to promote tolerance of procedure." Plan of care was not followed.

This order must be complied with by:

December 9, 2010

### 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;
- any submissions that the Licensee wishes the Director to consider; and
- an address for service for the Licensee.

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

Director c/o Appeals Clerk Performance Improvement and Compliance Branch Ministry of Health and Long-Term Care 55 St. Clair Ave. West Suite 800, 8<sup>th</sup> floor Toronto, ON M4V 2Y2

Fax: 416-327-7603



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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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the Attention Registrar 151 Bloor Street West 9th Floor Toronto, ON M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8<sup>th</sup> Floor
Toronto, ON M4V 2Y2

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 <a href="https://www.hsarb.on.ca">www.hsarb.on.ca</a>.

Issued on this 9th day	y of December, 2010.
Signature of Inspector:	June Blon-
Name of Inspector:	June Osborn
Service Area Office:	London Service Area Office