



**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
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Direction de l'amélioration de la
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 30, 2015	2015_262523_0042	035654-15 / 035646-15	Critical Incident System

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE MISSISSAUGA ON L5H 2S6

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

EXETER VILLA
155 JOHN STREET EAST EXETER ON N0M 1S1

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

ALI NASSER (523)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 23 & 29, 2015

This Critical Incident inspection was related to allegations of abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Hairdresser, four Personal Support Workers, one family member and one resident.

The inspector(s) also toured the resident care areas and common areas, observed residents and care provided to them, observed staff-resident interactions, reviewed clinical records and plans of care for identified residents, reviewed related policies and procedures.

Ad-hoc notes were used during this inspection.

During the course of this inspection, Non-Compliances were issued.

5 WN(s)

4 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
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
<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 LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :



The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

An interview with the Administrator and a review of the staff interviews related to the incident revealed that PSW # 107 provided specific care interventions to resident # 001.

A review of resident # 001's plan of care revealed that the above interventions were not specified in the plan of care.

An interview with the Administrator and the Director of Care confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan.

The Administrator and the Director of Care confirmed that it is the home's expectation that the care set out in the plan of care would be provided to the resident as specified in the plan.

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 care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

- s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
- (a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
 - (b) is on at all times; O. Reg. 79/10, s. 17 (1).**
 - (c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
 - (d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
 - (e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
 - (f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
 - (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

Findings/Faits saillants :

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

Observation during inspection revealed a common area accessed by residents had no resident-staff communication system.

This was confirmed by the Administrator who also confirmed that it would be the home's expectation to have a resident-staff communication and response system that is available in every area accessible by residents.

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 home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

A review of the home's policy subject: Resident Abuse Reporting Procedure revealed that the policy directed staff that in any case of abuse or suspected abuse the employee witnessing or having knowledge of an incident shall immediately verbally report the same to their Supervisor or designate.

Staff interviews and record reviews revealed that the staff did not comply with the home's policy by not reporting to the Supervisor or designate of any alleged, suspected or witnessed incidents of abuse.

An interview with the Administrator and the Director of Care confirmed that the staff did not comply with the home's policy. They both confirmed that the home's expectation would be to report any witnessed or suspected abuse or neglect immediately as per the home's policy.

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 policy to promote zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

An interview with the Administrator and Director of Care confirmed that they did not report to the police immediately the incident of witnessed and suspected resident abuse.

They both confirmed that it was the home's expectation to report to the police force any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence.

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 appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :



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The licensee has failed to ensure that the resident's right to 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, was fully respected and promoted.

Observations during inspection revealed that the door to two offices in the home were left open and unattended and Personal Health Information (PHI) was left on the desks and not kept confidential.

Both offices are located in the hallways, residents and families were observed walking in those hallways.

Both observations were confirmed by the Administrator who also confirmed that it was the home's expectation to have PHI kept confidential and not readily accessible.

Issued on this 30th day of December, 2015

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

Original report signed by the inspector.