



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
prévus le Loi de 2007 les
foyers de soins de longue

Health System Accountability and Performance
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 10, 11, 12, 13, Sep 26, 27, 2012	2012_049143_0032	Complaint

Licensee/Titulaire de permis

KEAY NURSING HOMES INC
10-112 Red Pine Road, P.O. Box 21, GRAND BEND, ON, N0M-1Z0

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

E. J. MCQUIGGE LODGE
38 Black Diamond Road, P.O. Box 68, Cannifton, ON, K0K-1K0

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

Log # O-000827-12, O-000853-12 & O-000927-12 (P.M. September 27, 2012)
During the course of the inspection, the inspector(s) spoke with The Acting Administrator, the Director of Nursing, Registered Nurse's, Registered Practical Nurses, Personal Support Workers, RAI coordinators, Office Administrative staff, residents and family members.

During the course of the inspection, the inspector(s) Reviewed policies and procedures, staffing plan and work routines, reviewed bathing schedules, heat management program, observed meal service and observed resident care.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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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
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 O.Reg 79/10, s. 31. Nursing and personal support services
Specifically failed to comply with the following subsections:

s. 31. (3) The staffing plan must,

- (a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;**
- (b) set out the organization and scheduling of staff shifts;**
- (c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;**
- (d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and**
- (e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).**

Findings/Faits saillants :

1. The Staffing plan (Resident Services Manual Section 3.0 Human Resources page 14-18) was reviewed and discussed with the Acting Administrator/Director of Nursing. This plan did not include a back-up plan for nursing and personal care that addressed situations when staff cannot come to work.

The Licensee has failed to comply with Ontario Regulation 79/10 section 31. (3) (d).

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following subsections:

- s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

Findings/Faits saillants :



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1. On July 9, 2012 resident # 3 reported to the inspector that on July 7, 2012 a tub bath was not offered. Resident # 3 was provided a sponge bath. The resident reported that this was not their method of choice and an alternative time for a bath by method of their choice was not offered.

On July 9, 2012 resident # 1 was interviewed. Resident report that during a recent heat wave he did not receive a bath by a method of his choice. Resident #1 reported that a tub bath or a shower was not offered and a sponge bath was provided at the sink. Resident report that preference would have been a bath which was not provided and an alternative time and date for a tub bath was not provided.

On July 10, 2012 resident # 2 reported that during the recent heat wave a shower was not offered. Resident # 2 reported that an alternative time was not offered related to bathing by method of choice that being a shower. Resident # 2 reported that a sponge bath was provided.

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 all residents receive a bath by the method of their choice, to be implemented voluntarily.

Issued on this 27th day of September, 2012

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

A handwritten signature in black ink, appearing to read "P. Miller", is written over a horizontal line within the signature box.