



**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**

**Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255**

**Bureau régional de services de
Hamilton
119, rue King Ouest, 11^{ième} étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255**

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
Oct 18, 2013	2013_214146_0054	H-000057- 13, H- 000485-13	Complaint

Licensee/Titulaire de permis

**FOYER RICHELIEU WELLAND
655 Tanguay Ave, WELLAND, ON, L3B-6A1**

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

**FOYER RICHELIEU WELLAND
655 TANGUAY AVENUE, WELLAND, ON, L3B-6A1**

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

BARBARA NAYKALYK-HUNT (146)

Inspection Summary/Résumé de l'inspection



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

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

This inspection was conducted on the following date(s): October 17, 2013.

This inspection was conducted with Robin Mackie in attendance.

During the course of the inspection, the inspector(s) spoke with the financial director acting in the administrator's absence, Director of Care (DOC), registered staff on night shift and day shift, Personal Support Workers (PSW'S) on night shift and day shift and residents.

During the course of the inspection, the inspector(s) toured the home, reviewed the night staff routine, resident health records and observed residents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



**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**

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:

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 :



1. The licensee did not fully respect and promote the resident's right to give or refuse consent to any treatment, care or services for which consent is required by law. In October 2013 at 0605 hours, inspectors observed that 2 residents, resident #002 and #003 were sitting up in Broda chairs in the lounge, fully dressed but soundly sleeping with heads slumped downward and forward. 2 night staff, interviewed separately, both confirmed that both residents had been given total AM care at 0515 this morning as instructed by the home and confirmed by the written memo entitled "Night Routine" of August 6, 2013; both residents had to be awakened to be bathed and dressed and transferred to their chairs; resident #003 had attempted to sleep through the bath and tried to turn over frequently; resident #002 was very angry, scratching at caregivers and resistive to care. The staff reported to inspectors that they had been directed to do total AM care on five identified residents on night shift between 0500 and 0630. Staff believe that resident #002 is always resistive to the early morning awakening and care because the resident is trying to refuse the care and sleep longer.

Staff have not allowed the resident to refuse the AM care. This was confirmed by 3 staff interviews and the health record.

The night staff stated that resident #005 used to be one of the five identified residents awakened at 0500 to be bathed and also had aggressive responsive behaviours. Behavioural Support staff were consulted and suggested the early morning AM care caused responsive behaviours. The resident's responsive behaviours stopped once the resident was permitted to waken on own, according to the staff. [s. 3. (1) 11. ii.]

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 following resident rights are respected and promoted: 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, to be implemented voluntarily.



Ministry of Health and
Long-Term Care

Ministère de la Santé et des
Soins de longue durée

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

Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée

Issued on this 18th day of October, 2013

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

BARB NAYKALYK-HUNT