Ontario

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
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

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

Telephone: 416-325-9297
1-866-311-8002

Facsimile: 416-327-4486

Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8iém étage
Toronto, ON M4V 2Y7

Téléphone: 416-325-9297
1-866-311-8002

Télécopieur: 416-327-4486

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 18, 2010	2010_125_2630_17Aug154857	Critical Incident #2630-000029-10 Intake Assessment Tracking Log # T0505

Licensee/Titulaire
Chartwell Master Care LP,100 Milverton Drive,Suite 700, Mississauga ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée
Aurora Resthaven, 32 Mill Street, Aurora ON L4G 2R9

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

Marsha Hardwick #125

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection regarding seat belts.

- During the course of the inspection, the inspector spoke with:
- Administrator
- Director of Care
- MDS-RAI Co-coordinator
- Staff
- Residents

During the course of the inspection, the inspector reviewed: Identified health care records, Restraint Binder, Restraints - Physical policy and inspected all resident units,

The following Inspection Protocol was used during this inspection:

- Minimizing of Restraining
- Medication Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

- 4 WN
- 3 CO: CO#001, #002, #003

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 O. Reg. 79/10, s.110 (1)1,3. Every Licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the ACT:

1. Staff apply the physical device in accordance with any manufacturer's instructions.
3. The physical device is not altered except for routine adjustments in accordance with any manufacture's instructions.

Findings:

- On July 6, 2010 a resident had a "seat belt under their chin" (CIS 2630-000029-10)
- On August 18, 2010 manufacturer's instructions for a physical device were not available in the home
- On August 18, 2010 five residents seat belts were not applied in accordance to the manufacturer's instructions as they were applied loosely:
- On August 18, 2010 an identified resident's seat belt was altered and was tied in a knot.

Since the July 6, 2010 seat belt incident the home has decreased the number of seat belts from 109 to 60.

Additional Required Actions:
CO#- 001 Will be served on the licensee. Refer to the Orders of the Inspector's form

WN #2: The Licensee has failed to comply with O. Reg. 79/10, s.129 (1) (a)(ii) Every Licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart
(ii) that is secure or locked

Findings:

- On October 1, 2010 at 0920 hours a medication cart in the hall beside the elevator was unlocked and unattended. Ten residents were sitting across the hall near the unlocked and unattended medication cart. The medication nurse was at the nursing station.
- On October 1, 2010 at 1315 hours a medication cart near the dining room was unlocked and unattended. Eight residents were sitting in the hall near the unlocked and unattended medication cart.

Additional Required Actions: CO#- 002 will be served on the licensee. Refer to the Orders of the Inspector's form
WN #3 The Licensee has failed to comply with O. Reg. 79/10, s.130 (1) Every Licensee of a long-term care home shall ensure the security of the drug supply, including the following: **1. All areas where drugs are stored shall be kept locked at all times, when not in use.**
Findings: • On October 1, 2010 at 1020 hours a medication room door was left unlocked and unattended. A non registered staff member has access to the medication room.
Additional Required Actions: CO#- 003 will be served on the licensee. Refer to the Orders of the Inspector's form

WN #4: The Licensee has failed to comply with O. Reg. 79/10, s.110 (2) 1. Every Licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: **1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.**
Findings: • On August 18, 2010 an identified resident was in a wheel chair wearing a seat belt which was not ordered or approved by a physician or registered nurse in the extended class. The seat belt was removed immediately by staff.

Signature of Licensee or Representative of Licensee **Signature du Titulaire 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:** (if different from date(s) of inspection).

Signature of Licensee or Representative of Licensee Signature du Titulaire 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.
Katherine Jackson Oct 12/10	Oct 12/10 Maureen Woodcock
Title: Acting Administrator	Date: Oct 12/10
	Date of Report: (If different from date(s) of inspection).

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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

Orders of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Marsha Hardwick	**Inspector ID #**	125
Log #:	T0505		
Inspection Report #:	2010_125_2630_17Aug154857		
Type of Inspection:	CIS Follow-up		
Date of Inspection:	August 18, September 30, 2010		
Licensee:	Chartwell Master Care LP,100 Milverton Drive,Suite 700, Mississauga ON L5R 4H1		
LTC Home:	Aurora Resthaven, 32 Mill Street, Aurora ON L4G 2R9		
Name of Administrator:	Della Skelsey		

To Chartwell Master Care LP, you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: **O. Reg. 79/10, s.110 (1) 1,3. Every Licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the ACT:**

1. **Staff apply the physical device in accordance with any manufacturer's instructions.**
3. **The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions**

Order:

The licensee shall develop a plan to ensure that physical restraint devices are applied in accordance with the applicable manufacturer's instructions and physical devices are not altered except for routine adjustments in accordance with specific manufacturer's instructions.

The licensee shall submit the plan to this inspector at 465 Davis Drive, 3rd Floor, Newmarket, ON, L3Y 8T2 on or before November 12, 2010.

Grounds:
• On July 6, 2010 it was reported a resident had a seat belt under their chin (CIS 2630-000029-10) • On August 18, 2010 manufacturer's instructions for a physical device were not available in the home • On August 18, 2010 five residents seat belts were not applied in accordance to the manufacturer's instructions as they were applied loosely: • On August 18, 2010 one resident's seat belt was altered and was tied in a knot.
This order must be complied with by: November 12, 2010

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(b)
Pursuant to: **O. Reg. 79/10, s.129 (1) (a)(ii) Every Licensee of a long-term care home shall ensure that,** **(a) drugs are stored in an area or a medication cart** **(ii) that is secure or locked**			
Order: The licensee shall develop a plan to ensure that drugs are stored in a locked medication cart. The licensee shall submit the plan to this inspector at 465 Davis Drive, 3rd Floor, Newmarket, ON, L3Y 8T2 on or before November 12, 2010.			
Grounds: • On October 1, 2010 at 0920 hours a medication cart in the hall beside the elevator was unlocked and unattended. Ten residents were sitting across the hall near the unlocked and unattended medication cart. The medication nurse was in the nursing station talking to staff members. • On October 1, 2010 at 1315 hours a medication cart near the dining room was unlocked and unattended. Eight residents were sitting in the hall near the unlocked and unattended medication cart.			
This order must be complied with by:	November 12, 2010		

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(b)
Pursuant to: **O. Reg. 79/10, s.130 (1) Every Licensee of a long-term care home shall ensure the security of the drug supply, including the following:** 1. **All areas where drugs are stored shall be kept locked at all times, when not in use.**			

Order:
The licensee shall develop a plan to ensure all areas where drugs are stored will be kept locked at all times when not in use. The licensee shall submit the plan to this inspector at 465 Davis Drive, 3rd Floor, Newmarket, ON, L3Y 8T2 on or before November 12, 2010.
Grounds: • On October 1, 2010 at 1020 hours a medication room door was left unlocked and unattended. A non registered staff member had access to the medication room.

This order must be complied with by:	November 12, 2010

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of these Orders and to request that the Director stay these Orders 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;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) 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, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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, these Orders 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 Orders 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
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th 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 www.hsarb.on.ca.

Issued on this 12th day of October, 2010.	
Signature of Inspector:	Marsha Hardwick
Name of Inspector:	Marsha Hardwick
Service Area Office:	Toronto