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

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, 11iém étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ 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
December 8, 10, 2010	2010_146_2618_07Dec162011	Complaint H-02418

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

Long-Term Care Home/Foyer de soins de longue durée
Chateau Gardens Long term Care Centre, 120 Wellington Street, Niagara on the Lake, ON., L0S1J0

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

Barbara Naykalyk-Hunt, #146

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: the Administrator, the Director of Care and the Assistant Director of Care.

During the course of the inspection, the inspector: reviewed the health file of an identified resident.

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

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

2 WN

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)

Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected.

Findings:

1. According to the health file of an identified resident, the resident was a long term participant in a specific lifestyle choice and had clearly expressed the wish to be allowed to continue this choice while residing at the home. The resident was told that he/she was not permitted to do so because it was against home policy. However the home's policy does permit the activity under certain conditions. The staff chose not to permit this particular resident to participate in the activity because it was not good for his health.

WN #2: The Licensee has failed to comply with O.Reg. 79/10, s.148(3)

Before discharging a resident from the home under clause 145 (3) (a), (b) or (d), the licensee shall offer to,
(a) assist the resident in planning for discharge by identifying alternative accommodation, health service organizations and other resources in the community; and
(b)contact appropriate health service organizations and other resources in the community or refer the resident to such organizations and resources

Findings:

1. The health file indicates that an identified resident was told on at least 2 occasions in the month prior to discharge that he/she would possibly be discharged from the home. There was no assistance given to the resident or contacts made to appropriate community resources for alternate living arrangements. CCAC was called the actual day of discharge. The resident had mentioned living with a family member but the health file indicates that the home was informed by the family prior to the resident leaving the home that the resident would not be living with them.

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.**

	Barbara Daylight-Hunt Feb, 2011
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).