Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 4, 2021	2021_961243_0001	012094-21	Critical Incident System

Licensee/Titulaire de permis

DTOC Long Term Care LP, by its general partner, DTOC Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.
161 Bay Street, Suite 2100 TD Canada Trust Tower Toronto ON M5J 2S1

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

Chateau Park Long Term Care Home
2990 B Riverside Drive West Windsor ON N9C 1A2

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

ANGELA FINLAY (705243)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 2, 2021.

The following intake was completed in this Critical Incident inspection related to a fall.

Ali Nasser Inspector #523 was also present during the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Directors of Care (DOCs), registered nurses (RNs), personal support workers (PSWs) and a housekeeper.

The inspector(s) also toured the home, observed residents, resident rooms, common areas and IPAC practices and reviewed residents health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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). 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 :

1. The licensee has failed to ensure that the plan of care related to a specific intervention for a specific resident provided clear directions to staff and others who provide direct care to the resident.

The plan of care for this specific resident provided different directions for staff to implement a specific intervention.

This resident was observed with one of the specified interventions in place.

During an interview with the acting DOCs, they acknowledged that the directions in the plan of care were not clear or consistent and that they needed to be updated.

Sources: The residents clinical records, observations and an interview with the acting DOCs. [s. 6. (1) (c)]

2. The licensee has failed to ensure that a specific intervention was provided to two different residents as specified in the plan of care.

The plan of care for the residents directed staff to implement specific interventions.

Upon observation, both residents were seen without any of the specific interventions applied.

During an interview with an RN and a PSW they observed and acknowledged that both residents did not have the specified interventions applied.

Sources: Residents clinical records, observations, interviews with staff. [s. 6. (7)]

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 is provided to the residents as specified in the plan of care, to be implemented voluntarily.

Issued on this 4th day of November, 2021

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

Original report signed by the inspector.