Ontario

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Feb 25, 2019	2019_575214_0005	011509-18, 022220-18, 027169-18	Complaint

Licensee/Titulaire de permis

Maryban Holdings Ltd.
3700 Billings Court BURLINGTON ON L7N 3N6

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

Oakwood Park Lodge
6747 Oakwood Drive NIAGARA FALLS ON L2G 0J3

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

CATHY FEDIASH (214), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 7, 8, 11, 2019.

Please note: This Complaint Inspection was conducted simultaneously with Critical Incident System (CIS) Inspection 2019_575214_0006 / 022049-18 and Follow up Inspection 2019_575214_0004 / 012859-18.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC).

During the course of the inspection, the inspector reviewed resident clinical records.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Dignity, Choice and Privacy
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the care plan was provided to the resident as specified in the plan.

During a complaint inspection, log #011509-18, it was identified that resident #001 was admitted to the home on an identified date for a specified type of care.

Prior to the resident's admission, a specified request was made by an identified person(s) that the resident have an identified item with their dinner and indicated that they would supply the identified item for the resident to have during the stay.

The home agreed to accommodate this request and a physician's order had been obtained for the identified item.

A review of the resident's 24 hour care plan indicated that the plan of care included that the resident was to have the identified item with their dinner. This information was also transcribed onto the Treatment Administration Records (TAR) for a specified time period.

During review of these records it was identified that there was no documentation to indicate that the identified item had been given or offered to the resident. Interview with the Director of Care on an identified date, confirmed that staff had forgotten to offer the resident the identified item at dinner during a specified period of time.

It was confirmed through record reviews and during an interview with the DOC that the care set out in the care plan was not provided to the resident as specified in the plan. [s. 24. (6)]

Issued on this 27th day of February, 2019

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

Original report signed by the inspector.