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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 19, 2013	2013_102116_0029	T-277-13	Complaint

Licensee/Titulaire de permis

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 ou des inspecteurs

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 11, 12,15, 16, 2013

Inspector attended the home to conduct an inspection of one complaint (Log # T -277-13) pertaining to resident rights.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Social Worker,Registered Staff, Personal Support Workers and Housekeeping staff members.

During the course of the inspection, the inspector(s) reviewed resident health record, education records on zero tolerance for abuse and whistle-blowing, staff schedules and the homes prevention of abuse policy.

The following Inspection Protocols were used during this inspection:
Admission Process

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

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for Resident #1 set out clear directions to staff and others who provide direct care to the resident.

- Review of Resident #1's health record revealed a letter from a specialist that documents specific requirements needed due to a medical condition. The letter was resent to the home again four months after the original sent date due to Resident #1 stating the requirement still is not being met.
- The plan of care was updated after the inspection was in progress. Although staff reported to the inspector that they are implementing the specific requirement for Resident #1 there were no directions provided in the written plan of care for staff and others on how to meet the specific requirement.

The plan of care for Resident #2 does not provide clear directions to staff regarding transfers.

- Interviews with Registered and direct care staff members confirm that Resident #2 experienced a significant change in status which resulted in the resident requiring two persons for all transfers.
- The plan of care for Resident #2 documents that the resident requires one person transfer.
- On a specified date, a personal support worker (PSW) was observed transferring Resident #2 from a sitting to standing position without the assistance of another staff member [s. 6. (1) (c)]

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 plan of care for Resident #1 and Resident #2 set out clear directions to staff and others who provide direct care to the resident's, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring techniques when assisting Resident #2.
- On a specified date, a personal support worker (PSW) was observed transferring Resident #2 from a sitting to standing position. The PSW experienced difficulty and requested the assistance of the inspector to execute the transfer. The inspector obtained another PSW to assist with transferring the resident.
- Interviews held with staff members confirmed Resident #2 requires two persons for all transfers due to a significant change in status [s. 36.]

2. - The identified PSW confirmed not being aware of the residents current lift and transfer requirements [s. 36.]

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 staff use safe transferring techniques when assisting Resident #2, to be implemented voluntarily.

Issued on this 19th day of August, 2013

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