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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 25, 2015	2015_263524_0027	022540-15	Resident Quality Inspection

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

CHATEAU GARDENS ELMIRA LONG TERM CARE CENTRE
11 Herbert Street Elmira ON N3B 2B8

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

INA REYNOLDS (524), NANCY JOHNSON (538), NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 14, 15, 16, 17, 18, 21, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Services Manager, the Food and Nutrition Manager, the Program and Support Services Manager, the Resident Assessment Instrument (RAI) Coordinator, two Corporate Regional Consultants, two Registered Nurses, two Registered Practical Nurses, nine Personal Support Workers, the Resident Council President, forty Residents and three Family Members.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, meal and snack service, medication administration, medication storage area, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, staff education records, minutes of meetings related to the inspection, reviewed relevant policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

2 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	Legendé 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

A. On September 14, 2015, during the tour of the home the inspector was able to enter the servery on both the first floor and second floor of the home without activating the key pad on the door to enter the servery. The servery steamtable was on and warm to touch.

B. On September 14, 2015, the inspector observed the chapel area exit door in the basement to be turned off and was not able to open the door when entering the code in to the key pad.

The Program and Support Services Manager confirmed on September 14, 2015, that the exit door in the chapel was not working properly and that the home was waiting for a part to come in.

The Administrator and the inspector activated the chapel exit door, and were able to go out the exit door in to an unsecured area outside. The wheelchair access button was pushed to reopen the door. The Administrator was not able to reopen the door and confirmed that the door should have activated from the outside to enter the home but remained locked.

The Administrator also confirmed that the key pads for both the servery’s were broken and that they had hoped to have them fixed by the end of the week.

The Administrator confirmed that the home's expectation was that the exit door should open from the outside so that residents are not locked outside and that the servery doors would be locked at all times when unsupervised and would require a code to be entered into the key pad to unlock the doors.

The licensee failed to ensure that the home was a safe and secure environment for its residents. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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. (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 care set out in the plan of care was provided to the resident as specified in the plan.

Record review of the plan of care under the eating focus on PointClickCare for an identified resident revealed that an assistive device was required for beverages for the resident to safely consume fluids.

Observation of the snack service revealed that the resident was not provided with this assistive device while consuming a beverage. This was confirmed by the Registered Nurse. The resident was heard coughing twice while drinking a beverage.

The Food and Nutrition Manager indicated that assistive devices were listed on the residents' diet list on the snack cart and confirmed that it was the home's expectation that staff were to follow the diet list to ensure that each resident was provided with the care as set out in their plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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Issued on this 25th day of September, 2015

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

Original report signed by the inspector.