Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Licensee Copy/Copie du titulaire de permis

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 21, 22, 23, 2012	2012_054133_0012	Critical Incident

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 LANCASTER LONG TERM CARE CENTRE
105 MILITARY ROAD NORTH, P.O. BOX 429, LANCASTER, ON, K0C-1N0

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Assistant Director of Care, registered and non registered nursing staff, a housekeeping services staff member,the activities coordinator, the lead for the restorative care program and residents.

During the course of the inspection, the inspector(s) conducted two Critical Incident inspections (Log O-002694-11 and O-000470-12), reviewed documentation related to these reported Critical Incidents, reviewed policy INF-II-18 titled "Outbreak Management Process" with revision date June 2010, reviewed policy INF-II-19 titled "Outbreak Management" with revision date August 2010, inspected the resident's bedrooms for the presence of point of care hand hygiene agents.

The inspection occurred on site March 21st and 22nd 2012.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

3. A resident who is missing for three hours or more.

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. As per O. Reg 79/10, s. 107 (1)5, the licensee failed to ensure that the Director was immediately informed of an outbreak of respiratory illness.

On February 19th 2012, a respiratory outbreak was declared at the home by the local health unit. The Director was informed 5 days later, on February 24th 2012, via Critical Incident Report 2680-000004-12. (Log O-000470-12)

Issued on this 23rd day of March, 2012

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

Jessica Lapensée