



**Ministry of Health and
Long-Term Care**

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

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

**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**

Bureau régional de services de
London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 9, 2015	2015_262523_0032	030097-15	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

Chartwell Parkhill Long Term Care Residence
250 TAIN STREET P.O. BOX 129 PARKHILL ON N0M 2K0

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

ALI NASSER (523)

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): November 5 & 6, 2015

**During the course of the inspection, the inspector(s) spoke with the
Administrator/Director of Care, two Registered Staff members and one Personal
Support Worker.**

The following Inspection Protocols were used during this inspection:



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Admission and Discharge

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

2 WN(s)

2 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.



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WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A review of the home's policy "Discharging a Resident", policy number: LTC-CA-WQ-100-02-09 revealed that if a resident opted to be discharged home, the resident will be assessed by the physician and the physician will document the resident's cognitive and physical capabilities.

A clinical record review and staff interviews revealed that the home did not comply with their own policy when discharging a resident.

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident



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Specifically failed to comply with the following:

- s. 148. (3) Before discharging a resident from the home under clause 145 (3) (a), (b) or (d), the licensee shall offer to,**
(a) assist the resident in planning for discharge by identifying alternative accommodation, health service organizations and other resources in the community; and O. Reg. 79/10, s. 148 (3).
(b) contact appropriate health service organizations and other resources in the community or refer the resident to such organizations and resources. O. Reg. 79/10, s. 148 (3).

Findings/Faits saillants :

The licensee has failed to ensure that before discharging a resident from the home the licensee should offer to contact appropriate health service organizations and other resources in the community or refer the resident to such organizations and resources.

A staff interview revealed that before discharging a resident, the home did not offer to contact community health organizations that were involved in resident's care.

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 before discharging a resident from the home the licensee should offer to contact appropriate health service organizations and other resources in the community or refer the resident to such organizations and resources, to be implemented voluntarily.



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Issued on this 9th day of November, 2015

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

Original report signed by the inspector.