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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
October 19, 2010	2010_105_2632_19Oct091947	L-01259 Mandatory Report

Licensee/Titulaire
Chartwell Master Care LP 100 Milverton Dr. Suite 700 Mississauga ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée
Chateau Gardens Parkhill LTCC -250 Tain St. PO Box 129 Parkhill ON N0M 2K0

Name of Inspector/Nom de l'inspecteur(s)
June Osborn #105

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Mandatory Report inspection related to inadequate resident care.

During the course of the inspection, the inspector spoke with the charge nurse, an RPN, a PSW, and the administrator/DOC.

During the course of the inspection, the inspector reviewed the resident's medical record and plan of care, reviewed Policy No.: LTCE-RCA-E-004 Section Title: Safety Subject Title: Critical Incident Report (CIS).

The following Inspection Protocols were used in part or in whole during this inspection:

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4WN
4CO

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007 c.8 s.24(1)(1)**

A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to a resident.

Findings:

1. Mandatory Report 2632-000014-10 identifies the incident as occurring on September 26, 2010, and incident as being reported September 29, 2010.

Inspector ID #:	105

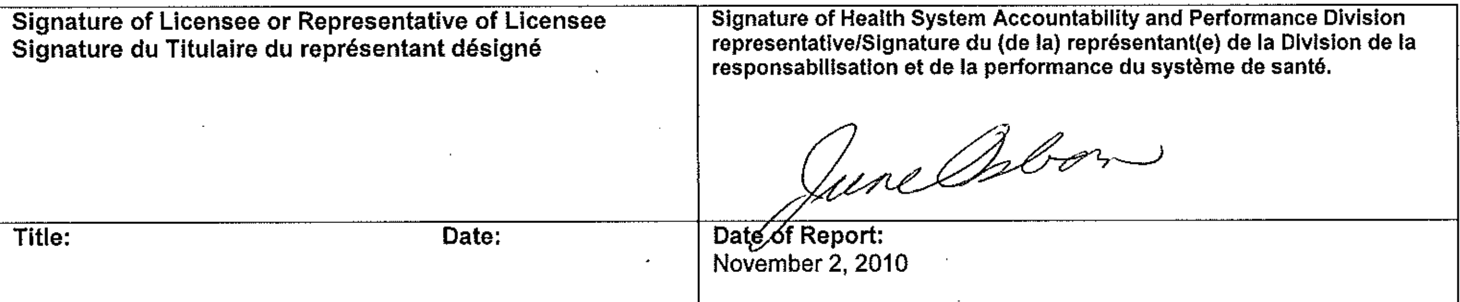
Additional Required Actions:

CO # - 001 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007c.8 s.3(1)3.** **Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:** **3. Every resident has the right not to be neglected by the licensee or staff.**	
Findings: 1. **Resident was placed on a bed pan at 2130 hours September 25, 2010, the bed pan was discovered at 0530 September 26, 2010 .** 2. **Staff documented on the resident's "Restraint Monitoring Record" Position change at 2300 hours, 0300 hours and 0500 hours, and yet the bed pan was discovered at 0530.**	
Inspector ID #:	105
Additional Required Actions: **CO #** - 002 was served on the licensee. Refer to the "Order(s) of the Inspector" form.	

WN #3: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007,c. 8 s.6(1)(c)** **Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,** **(c) clear directions to staff and others who provide direct care to the resident.**	
Findings: **1. Resident's plan of care does not mention the resident's ability to ask for a bed pan or that she uses a bed pan when in bed.**	
Inspector ID #:	105
Additional Required Actions: **CO #** - 003 was served on the licensee. Refer to the "Order(s) of the Inspector" form.	

WN #4: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c.8 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.**	
Findings: **1. Resident's plan of care on page 8 under "Focus" "Use and application of an external device for prevention of injury to self or to others characterized by high risk for injury/falls, impaired mobility" "Interventions" "reposition q2h and prn"; yet documented positioning occurred at 2300 hours, 0300 hours and 0500 hours.**	
Inspector ID #:	105
Additional Required Actions: **CO #** - 004 was served on the licensee. Refer to the "Order(s) of the Inspector" form.	



Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**		**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title:	**Date:**	**Date of Report:** November 2, 2010

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
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Direction de l'amélioration de la performance et de la conformité

Revised for Publication

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	June Osborn	**Inspector ID #**	105
Log #:	L-01259		
Inspection Report #:	2010_105_2632_19Oct091947		
Type of Inspection:	Mandatory Report		
Date of Inspection:	October 19, 2010		
Licensee:	Chartwell Master Care LP100 Milverton Dr. Suite 700 Mississauga ON L5R 4H1		
LTC Home:	Chateau Gardens Parkhill LTCC		
Name of Administrator:	Lisa Smith		

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)
Pursuant to: LTCHA, 2007, S.O. 2007 c.8 s.24(1)(1) **A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:** **1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to a resident.**			
Order: The licensee shall report Mandatory reports immediately to achieve compliance with LTCHA, 2007, S.O. 2007 c.8 s.24(1)(1).			
Grounds: **1. Mandatory Report 2632-000014-10 identifies the incident as occurring on September 26, 2010, and incident as being reported September 29, 2010.**			
This order must be complied with by:	November 2, 2010		

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)
Pursuant to: LTCHA, 2007, S.O. 2007c.8 s.3(1)3. **Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:** **3. Every resident has the right not to be neglected by the licensee or staff.**			
Order: **The licensee shall ensure resident care is not neglected to achieve compliance with LTCHA, 2007, S.O. 2007,c.8 s.3(1)3.**			
Grounds: **1. [redacted] was placed on a bed pan at 2130 hours September 25, 2010, the bed pan was discovered at 0530 September 26, 2010 .** **2. Staff documented on the resident's "Restraint Monitoring Record" Position change at 2300 hours, 0300 hours and 0500 hours, and yet the bed pan was discovered at 0530.**			
This order must be complied with by:	November 2, 2010		

Order #:	003	**Order Type:**	e.g. Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA, 2007, S.O. 2007,c. 8 s.6(1)(c)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

Order:
The licensee shall ensure a resident's plan of care sets out clear directions to staff and others who provide care to the resident to achieve compliance with LTCHA, 2007, S.O. 2007, c.8 s.6(1)(c).

Grounds:
1. [redacted] plan of care does not mention the resident's ability to ask for a bed pan or that she uses a bed pan when in bed.

This order must be complied with by:	November 2, 2010

Order #:	004	**Order Type:**	e.g. Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA, 2007, S.O. 2007, c.8 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.

Order:
The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan to achieve compliance with LTCHA 2007, S.O. 2007, c.8 s.6(7).

Grounds:
1. [redacted] plan of care on page 8 under "Focus" "Use and application of an external device for prevention of injury to self or to others characterized by high risk for injury/falls, impaired mobility" "Interventions" "reposition q2h and prn"; yet documented positioning occurred at 2300 hours, 0300 hours and 0500 hours.

This order must be complied with by:	November 2, 2010

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board **and the**
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

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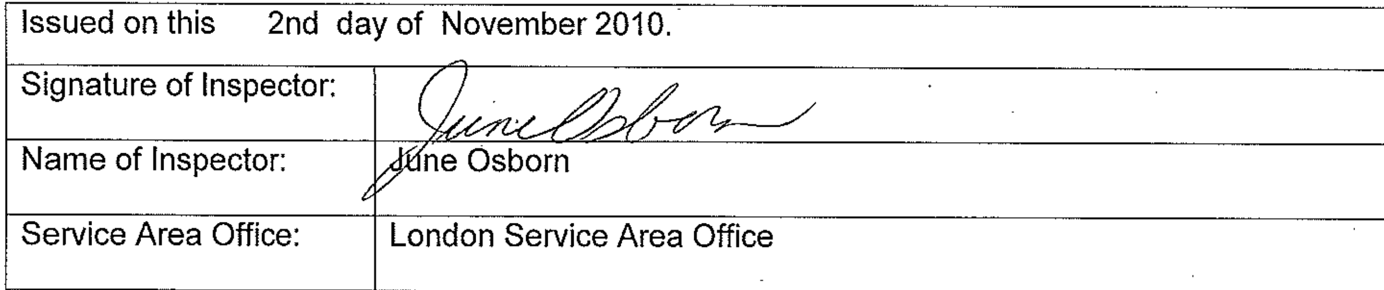

Issued on this 2nd day of November 2010.	
Signature of Inspector:	[signature]
Name of Inspector:	June Osborn
Service Area Office:	London Service Area Office