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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 15, 2013	2013_24304 _0007	L-000906-13	Critical Incident System

Licensee/Titulaire de permis

Leamington Court Inc.
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

Long-Term Care Home/Foyer de soins de longue durée

CHATEAU GARDENS LONDON LONG TERM CARE CENTRE
2000 Blackwater Road, LONDON, ON, N5X-4K6

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

DEIRDRE BOYLE (504)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 7, 2013 and November 12, 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one Registered Nurse, two Registered Practical Nurses, two Personal Support Workers and one Resident.

During the course of the inspection, the inspector(s) reviewed the Critical Incident report, a Resident's health care record, the Home's Responsive Behaviour - Aggressive or Violent Episode policy - Effective Date May 2012, Close Resident Monitoring Records, Dementia Observation Records and observed Resident care.

The following Inspection Protocols were used during this inspection: Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. 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 set out clear direction to staff to prevent triggering a Resident's responsive behaviours and to manage a Resident's responsive behaviours. The plan of care did not include what the Resident's triggers were. This was confirmed by a Registered Practical Nurse, a Registered Nurse and the Director of Care. [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 there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure that the plan of care for the Resident addressed the Resident's mood and behaviour patterns, specifically the plan of care did not address the Resident's frequent agitation and restlessness during a specific time frame each day.

The Licensee failed to ensure that any identified responsive behaviours and interventions to minimize the behaviours were documented in the plan of care. This was confirmed by the Director of Care and by a Registered Practical Nurse. [s. 26. (3) 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 requirements of this section are met with respect to every plan of care; specifically: Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

Issued on this 23rd day of December, 2013

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