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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 15, 2016	2016_415190_0012	009260-16	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

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

SANDRA FYSH (190)

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): May 18, 2016

This complaint inspection was related to a complaint regarding a post-fall assessment of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care, Registered Nurse, Registered Practical Nurse and Personal Support Worker.

The following Inspection Protocols were used during this inspection:

Falls Prevention

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.

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. (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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the residents as specified in the plan.

The home failed to follow-up information in a consultation note for a resident's plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the plan of care was reviewed and revised when care needs changed.

Resident #001 sustained a fall. A post-fall assessment was conducted, and the resident was identified as a high risk for falls.

Registered Practical Nurse #105 and Personal Support Worker #104 both confirmed that the most recent copy of the written plan of care is located on the resident chart in the nursing charting room. The risk for falls on this plan of care was identified as medium risk for falls.

A review of the electronic version of the plan of care revealed that it also identified the resident as a medium risk for falls.

Registered Nurse #103, Registered Practical Nurse #105 and Personal Support Worker #104 stated that a white board located in the charting area also listed all residents identified as high risk for falls. Resident #001 was not listed on this board. The staff members confirmed that resident #001 was not listed on the board.

The plan of care stated that an "apple" was to be placed over the nameplate at the entrance to the residents' door to denote a high risk for falls, but an apple was not present over the residents' nameplate. This was confirmed by Registered Nurse #103. [s. 6. (10) (b)]

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 with ensuring that the plan of care is reviewed and revised when care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that actions taken with respect to a resident under a program, including assessments, re-assessments, interventions and the resident's responses to interventions are documented.

Resident #001 sustained a fall, that required the home to implement an assessment.

The assessment provided directions on the top of the sheet to guide the completion of it.

The assessment and re-assessment for resident #001 was not completed according to the directions for use as indicated on the top of the assessment form. [s. 30. (2)]

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 with ensuring that any actions taken with respect to a resident under a program, including assessments, re-assessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 15th day of June, 2016

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

Original report signed by the inspector.