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
Dec 31, 2013	2013_216144_0090	L-000848-13	Other

Licensee/Titulaire de permis

MERITAS CARE CORPORATION
567 VICTORIA AVENUE, WINDSOR, ON, N9A-4N1

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

CHATEAU PARK LONG TERM CARE HOME
2990 B RIVERSIDE DRIVE WEST, WINDSOR, ON, N9C-1A2

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

CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): December 11, 2013

Service Area Office Initiated Inspection.

During the course of the inspection, the inspector(s) spoke with ten residents, two visitors, the Director of Nursing, Food Service Supervisor, two Registered Nurses and Personal Service Workers and one Housekeeping Aide.

During the course of the inspection, the inspector(s) completed a tour of the home, observed the dining room lunch meal, reviewed four months of Resident Council Meeting minutes and the 2013 Building Maintenance Summary schedule.

The following Inspection Protocols were used during this inspection:
Dining Observation
Residents' Council

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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance. During dining room observation of the lunch meal, one resident was observed improperly positioned. The resident was not repositioned by staff until a request was made by the Inspector. [s. 73. (1) 10.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participate in the infection control program. Unlabeled resident personal items were observed in the tub room. The Director of Nursing confirmed the resident personal items should be labeled. [s. 229. (4)]

Issued on this 31st day of December, 2013

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

CAROLEE MILLINER.