Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
TORONTO, ON, M4V-2Y7
Telephone: (416) 325-9297
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8iém étage
TORONTO, ON, M4V-2Y7
Téléphone: (416) 325-9297
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 4, 5, 6, 8, 2012	2012_103164_0015	Critical Incident

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

AURORA RESTHAVEN
32 MILL STREET, AURORA, ON, L4G-2R9

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

GLORIA STILL (164)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care, Registered staff, Personal Support Workers (PSW), resident.

During the course of the inspection, the inspector(s) reviewed: the resident's health record, Responsive Behaviours Management Policy & Procedure NUR-V14, Aggressive or Violent Behaviour Policy & Procedure NUR-V-15. Observed resident.

Note: Existing Compliance Order issued in accordance with O. Reg. 79/10, s. 110. (2) during inspection #2012_103164_0011 conducted April 26, 30, May 1, 14, 24, 25, 2012, related to restraining by a physical device was not inspected as the due date has not passed.

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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee did not ensure the following was documented: the provision of care set out in the plan of care. The written plan of care for the identified resident did not include the provision of the care set out in the plan of care. PSW and registered staff reported potential behavioural triggers for the resident include an angry face and high pitched noises and/or voices. The written plan of care did not include this information. [s.6.(9)1.]
2. The licensee did not ensure that the written plan of care for the identified resident sets out clear directions to staff & others who provide direct care to the resident. Following the incident with a co-resident and an assessment by the Ontario Shores Community Nurse Clinician the written plan of care for the identified resident was not revised to include the specific non pharmacological interventions recommended to assist in managing the resident's behaviour. [s. 6. (1) (c)]
3. The licensee did not ensure the outcomes of the care set out in the plan of care were documented. The most recent Resident Assessment Protocol (RAP) for the identified resident, assessment review date (ARD) March 14, 2012, did not include documentation reflecting the outcome of the resident's aggressive behavioural interventions, i.e. since the last assessment the identified resident was involved in a physical altercation with a co-resident causing injury to the co-resident. [6. (9) 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 to ensure:
- that each resident's written plan of care sets out clear directions to staff and others who provide direct care to the resident
- that the following are documented:
1. the provision of care set out in the plan of care
2. the outcomes of the care set out in the plan of care, to be implemented voluntarily.

Issued on this 8th day of June, 2012

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

Gloria Dill