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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2015	2015_271532_0015	003327-15; 007549-15	Critical Incident System

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 ELMIRA LONG TERM CARE CENTRE
11 Herbert Street Elmira ON N3B 2B8

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

NUZHAT UDDIN (532)

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): May 06, 2015

These Critical incident inspections were completed related to improper treatment of a resident and medication incident/adverse drug reaction.

During the course of the inspection, the inspector(s) spoke with the former Administrator, Director of Care, Resident Assessment Instrument (RAI) Coordinator, Environmental Services Manager, Registered Practical Nurses, Personal Support Workers and Residents.
Inspector also toured the resident home areas, observed resident care provision; resident/staff interaction reviewed relevant resident's clinical records, relevant policies and procedures, as well as notes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
3 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted, every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Record review indicated that an identified Resident was found sitting alone in the tub filled with water, on the tub lift chair. The Environmental Service Manager (ESM) discovered the resident and remained with the resident in the tub room until the Personal Support Worker (PSW) returned.

The tub room observation indicated that there was an "important safety warning" posted in the tub room which stated "Supervision – Never leave a patient unattended (do not turn your back on the patient)."

In an interview the Lift and Transfer coach confirmed that this memo had been posted before the incident took place and believed that the poster came from the manufacturer.

The former Administrator also confirmed that the memo was posted and acknowledged that the resident was at risk of harm. The Former Administrator indicated the resident should not have been left sitting alone on the lift chair in the bathtub and care was not provided in a manner consistent with the resident's needs. [s. 3. (1) 4.]

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 following rights of residents were fully respected and promoted, every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Record Review revealed a concern that a resident may have been transferred using a lift with just one staff member present.

Registered Practical Nurse and Lift and transfer coach reported that the two staff members were needed for any transfer with the mechanical lift.

Policy called Mechanical Lifts and Resident transfer was reviewed and it stated that "two staff were required at all time when a mechanical device was used to transfer and or lift a resident."

In an interview the former Administrator reported that the PSW had lift and transfer coach training and was able to complete a return demonstration of the safe use of mechanical lifts.

The Administrator acknowledged that the staff member did not use safe transferring and positioning techniques when assisting the resident. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Record reviewed indicated that an identified Resident had an order for two specific treatments at the same time.

Record review indicated that the registered staff administered the wrong treatment. A staff member discovered the error when they went to replace the the medication. At that time the identified resident was out of residence. The Registered staff contacted the physician and advised family to take the resident to the hospital.

The Director of Care in an interview confirmed that the staff member was distracted and did not administer the drug in accordance with the directions. [s. 131. (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 drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 8th day of May, 2015

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

Original report signed by the inspector.