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
Mar 6, 2014	2014_254515_0003	L-000055-14	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

RAE MARTIN (515)

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): February 13, 2014.

During the course of the inspection, the inspector(s) spoke with the Director of Care, a Registered Nurse, a Registered Practical Nurse, a Resident and one family member.

During the course of the inspection, the inspector(s) toured one resident home area, reviewed resident clinical health records and observed care for the resident.

The following Inspection Protocols were used during this inspection:

Falls Prevention

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 has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident as evidenced by:

A) A resident had a fall, resulting in a fracture that required surgical repair and hospitalization.

B) An assessment was completed and documents the resident requires one person assist with transfers. A transfer logo posted behind the bed states the resident requires one person assist for pivot transfer.

C) The care plan in the health record and kardex posted on the back of the resident's bathroom door states the resident requires two person assist for pivot transfer.

D) A Registered Nurse confirmed the resident requires a one person assist for transfers and the kardex and transfer logo should be consistent. The kardex was updated to indicate the resident requires one person assist for pivot transfer. The Director of Care further confirmed the transfer logo and plan of care should be consistent. [s. 6. (1) (c)]

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Issued on this 7th day of March, 2014

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

RAE MARTIN