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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 14, 2015	2015_282543_0007	S-000769-15	Critical Incident System

Licensee/Titulaire de permis

THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

AU CHATEAU
100 MICHAUD STREET STURGEON FALLS ON P2B 2Z4

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

TIFFANY BOUCHER (543), SARAH CHARETTE (612)

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): April 7-10 & 13, 2015

This inspection was completed concurrently with Follow-up and Complaint inspections. Non-compliance related to s. 6 (7) was identified in the critical incident inspection and will be addressed in the Follow-up inspection #2015_282543_0008.

Throughout the inspection, the inspectors directly observed the delivery of care and services to residents in all home areas, directly observed medication passes, reviewed resident health care records, reviewed staffing patterns and reviewed various home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Human Resource Manager, the RAI coordinator, Registered Staff (RNs and RPNs) and Personal Support Workers (PSW).

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

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. (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 failed to ensure that there was a written plan of care for each resident that set out the goals the care was intended to achieve.

Inspector #612 reviewed a critical incident whereby, resident #002 had a fall with resulting injuries. The resident was assisted with their activities of daily living by S#217 whereby they left this resident to answer another call bell. Resident #009 fell on the floor resulting in injuries.

Inspector #612 reviewed this resident's care plan which identified that resident #009 was not to be left unattended while performing their activities of daily living. However, this resident's care plan did not identify goals related to the resident being at high risk for falling. S#202 confirmed that the care plan stated this resident was not to be left alone. Inspector #612 spoke with S#209, who confirmed that there were no goals listed in resident #002's care plan addressing their risk for falls and/or injuries. [s. 6. (1) (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 to ensure that resident #002's care plan sets out the goals the care is intended to achieve related to this resident's high risk of falling, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm to the resident immediately reported the suspicion and the information upon which it was based to the director.

Inspector #612 reviewed a critical incident whereby, resident #002 had a fall with resulting injuries. The resident was assisted with their activities of daily living by S#217 whereby they left this resident to answer another call bell. Resident #009 fell on the floor resulting in injuries.

Inspector reviewed this resident's health care record which indicated that the resident was transferred to hospital for assessment post fall, returned to the home and was transferred back to hospital later due to increased pain and was found to have sustained injuries. This incident occurred in January 2015 however, S#202 did not submit the Critical Incident Report until February 2015, under the mandatory reporting category of abuse/neglect from staff to resident. In the report S#202 stated that additional training will be provided to the registered staff regarding the importance of placing a call to the Ministry to initiate reporting to the Director.

Inspector #612 reviewed the Home's Abuse Policy which stated that for all alleged, suspected or witnessed incidents of abuse, actions included reporting to the Director, Long-Term Care Home's Branch, in accordance with the relevant LTC legislation and this policy. The person witnessing the abuse shall file the critical incident report (along with the Director of Care or Administrator). [s. 24. (1)]

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 a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm to the resident immediately reports to the Director, to be implemented voluntarily.

Issued on this 17th day of July, 2015

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

Original report signed by the inspector.