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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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159 rue Cedar Bureau 403
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Public Copy/Copie du public

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_0008	S-000734-15, 000735-15, 000736-15, 000737-15, 000738-15, 000739-15	Follow up

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

Ontario

Ministry of Health and Long-Term Care

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 7-10 & 13, 2015

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:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_282543_0027	543
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #002	2014_282543_0027	543
LTCHA, 2007 S.O. 2007, c.8 s. 6. (8)	CO #005	2014_282543_0027	543
O.Reg 79/10 s. 98.	CO #006	2014_282543_0027	612

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #009 as specified in the plan.

Inspector #612 reviewed a critical incident whereby resident #009 had a fall with resulting injuries. The resident was assisted with their activities of daily living by S#217 and 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. S#202 confirmed that the care plan stated this resident was not to be left alone on the toilet. The inspector interviewed S#210 and #211 who stated that this resident requires a mechanical lift, two HCA assist with their activities of daily living and are not to be left unattended. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

Inspector #543 reviewed this resident's care plan which identified, under the pain section, the intervention to apply cream to relieve discomfort associated with skin conditions.

Inspector #543 reviewed this resident's most recent Annual Care Conference notes, specifically related to skin conditions. A cream was added to the resident's care plan, to be applied to prevent these skin conditions. According to the Care Conference notes, this would be entered in scheduled events and CAR (cream application record) to prevent skin problems.

Inspector #543 reviewed resident #002's most recent CAR (cream application records) and identified the following:

-to apply cream at each brief change
-the cream was not applied 4 times. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

During the inspection, S#201, #202 and #203 informed the inspectors that an incident had occurred in March 2015, involving S#218. This staff member provided improper care to resident #003 that caused this resident to feel intimidated and unsafe. This resident reported to staff in the home, that when S#218 transfers them they do so incorrectly. This resident's plan of care indicated they are to be transferred with the use of a lift with the assist of 2 staff members. The resident reported that S#218 did not use the lift.

Inspector #543 interviewed S#201, #202 and #203 who spoke about an interview they had with resident #003 regarding the incident that occurred in March 2015. They stated that the resident confirmed they were transferred incorrectly by S#218 on multiple occasions and that they knew that whenever this staff member entered their room, they would not use a lift.

Inspector #543 reviewed resident #003's care plan specifically regarding ADL assistance, related to decreased mobility associated with their disease process. Goals for this resident included to maintain current abilities to perform activities of daily living and to receive required assistance with these activities. Interventions noted in this resident's care plan included, but were not limited to transferring with extensive assistance of 2 staff members using a lift. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse and/or neglect by staff member S# 218 and has also failed to ensure that S#218 was not provided any opportunity to further abuse and/or neglect residents in the home.

A previous compliance order (CO) was issued with regards to the duty to protect residents related to s. 19 (1) of the Long-Term Care Homes Act, 2007. The CO was issued on February 19, 2015.

The previous CO was related to a long standing history specifically related to the following regarding S#218:
-allegations of resident abuse and neglect,
-unsuitable performance,
-verbal altercations with other staff members,
-not providing care to residents as indicated in their plan of care.

During the inspection, S#201, #202 and #203 informed the inspectors that an incident had occurred in March 2015, involving S#218. This staff member provided improper care towards resident #003 that caused this resident to feel intimidated and unsafe. This resident reported to staff in the home, that when S#218 transfers them they do so incorrectly. This resident's plan of care indicated they are to be transferred with the use of a lift with the assist of 2 staff members. The resident reported that S#218 did not use a lift.

Inspector #543 interviewed S#201, #202 and #203 who spoke about an interview they had with resident #003 regarding the incident that occurred in March 2015. They stated that the resident confirmed they were transferred incorrectly by S#218 on multiple occasions and that they knew that whenever this staff member entered their room, they would not use a lift.

Inspector #543 reviewed resident #003's care plan specifically regarding ADL assistance,

related to decreased mobility associated with their disease process. Goals for this resident included to maintain current abilities to perform activities of daily living and to receive required assistance with these activities. Interventions noted in this resident's care plan included, but were not limited to transferring with extensive assistance of 2 staff members using a lift.

Supporting documentation from the precious CO, included a memo sent to the Human Resources Manager that advised that S#218 was not to work more than a specific number of hours in any pay period. Inspector #543 reviewed this staff member's scheduled hours of work for 12 weeks and identified that S#218 worked more than the specified hours over 6 pay periods.

Inspector #543 interviewed S#203 who indicated that S#218 no longer worked in the home. This staff member was informed of the investigation being conducted related to improper transferring of a resident and disciplinary action took place.

The CO issued on February 19, 2015 described that in order to protect all residents from abuse and/or neglect by the licensee or staff, specifically related to staff #218; this staff member was not to be afforded any opportunity to further abuse and/or neglect any residents of the home and that any form of abuse and/or neglect was to cease immediately. S#218 has continued to demonstrate a pattern of performance concerns in relation incidents of staff to resident abuse and/or neglect.

Supporting documentation from the CO issued on February 19, 2015, outlined that in S#218's personnel file, there were numerous memos from other staff members outlining concerns relative to S#218's conduct towards residents. As well, several "Notice of Action Required Forms" were filed with respect to staff S#218's improper conduct. As mentioned, this staff member received numerous disciplinary actions, and a memo from the Director of Care indicated that repeat incidents would result in termination. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

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.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TIFFANY BOUCHER (543), SARAH CHARETTE (612)
Inspection No. / No de l'inspection :	2015_282543_0008
Log No. / Registre no:	S-000734-15, 000735-15, 000736-15, 000737-15, 000738-15, 000739-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 14, 2015
Licensee / Titulaire de permis :	THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST 100 Michaud Street, STURGEON FALLS, ON, P2B-2Z4
LTC Home / Foyer de SLD :	AU CHATEAU 100 MICHAUD STREET, STURGEON FALLS, ON, P2B-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JACQUES DUPUIS

To THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_282543_0027, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that all staff provide care to residents as specified in their plan of care specifically related to residents #002, #003 and #009.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

During the inspection, S#201, #202 and #203 informed the inspectors that an incident had occurred on March 21, 2015, involving S#218. This staff member provided improper care to resident #003 that caused this resident to feel intimidated and unsafe. This resident reported to staff in the home, that when S#218 transfers them they do so incorrectly. This resident's plan of care indicated they are to be transferred with the use of a lift with the assist of 2 staff members. The resident reported that S#218 did not use the lift.

Inspector #543 interviewed S#201, #202 and #203 who spoke about an interview they had with resident #003 regarding the incident that occurred in March 2015. They stated that the resident confirmed they were transferred incorrectly by S#218 on multiple occasions and that they knew that whenever this staff member entered their room, they would not use a lift.

Inspector #543 reviewed resident #003's care plan specifically regarding ADL assistance, related to decreased mobility associated with their disease process. Goals for this resident included to maintain current abilities to perform activities of daily living and to receive required assistance with these activities.

Interventions noted in this resident's care plan included, but were not limited to transferring with extensive assistance of 2 staff members using a lift.
(543)

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

Inspector #543 reviewed this resident's care plan which identified, under the pain section, the intervention to apply cream to relieve discomfort associated with skin conditions.

Inspector #543 reviewed this resident's most recent Annual Care Conference notes, specifically related to skin conditions. A cream was added to the resident's care plan, to be applied to prevent these skin conditions. According to the Care Conference notes, this would be entered in scheduled events and CAR (cream application record) to prevent skin problems.

Inspector #543 reviewed resident #002's most recent CAR (cream application records) and identified the following:

-to apply cream at each brief change
-the cream was not applied 4 times.

(543)

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #009 as specified in the plan.

Inspector #612 reviewed a critical incident whereby resident #009 had a fall with resulting injuries. The resident was assisted with their activities of daily living by S#217 and 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. S#202 confirmed that the care plan stated this resident was not to be left unattended.

The inspector interviewed S#210 and #211 who stated that this resident required a lift, and the assist of two staff with their activities of daily living and are not to be left unattended.
(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 14, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_282543_0027, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee will ensure that with respect to the duty to protect, that all residents in the home will be protected from abuse and/or neglect by the licensee or staff; and the licensee shall prepare, submit and implement a plan which includes the following:

-what steps the licensee will take to ensure that all residents in the home are protected from abuse and/or neglect by the staff

This plan shall be submitted in writing to Tiffany Boucher, Long Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133 or email Tiffany.Boucher@ontario.ca. This plan must be submitted by July 31, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse and/or neglect by staff member S# 218 and has also failed to ensure that S#218 was not provided any opportunity to further abuse and/or neglect residents in the home.

A previous compliance order (CO) was issued with regards to the duty to protect residents related to s. 19 (1) of the Long-Term Care Homes Act, 2007. The CO was issued on February 19, 2015.

The previous CO was related to a long standing history specifically related to the

following regarding S#218:
-allegations of resident abuse and neglect,
-unsuitable performance,
-verbal altercations with other staff members,
-not providing care to residents as indicated in their plan of care.

During the inspection, S#201, #202 and #203 informed the inspectors that an incident had occurred in March 2015, involving S#218. This staff member provided improper care towards resident #003 that caused this resident to feel intimidated and unsafe. This resident reported to staff in the home, that when S#218 transfers them they do so incorrectly. This resident's plan of care indicated they are to be transferred with the use of a lift with the assist of 2 staff members. The resident reported that S#218 did not use a lift.

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Inspector #543 reviewed resident #003's care plan specifically regarding ADL assistance, related to decreased mobility associated with their disease process. Goals for this resident included to maintain current abilities to perform activities of daily living and to receive required assistance with these activities. Interventions noted in this resident's care plan included, but were not limited to transferring with extensive assistance of 2 staff members using a lift.

Supporting documentation from the precious CO, included a memo sent to the Human Resources Manager that advised that S#218 was not to work more than a specific number of hours in any pay period. Inspector #543 reviewed this staff member's scheduled hours of work for 12 weeks and identified that S#218 worked more than the specified hours for 6 pay periods.

Inspector #543 interviewed S#203 who indicated that S#218 no longer worked in the home. This staff member was informed of the investigation being conducted related to improper transferring of a resident and disciplinary action took place.

The CO issued on February 19, 2015 described that in order to protect all residents from abuse and/or neglect by the licensee or staff, specifically related

to staff #218; this staff member was not to be afforded any opportunity to further abuse and/or neglect any residents of the home and that any form of abuse and/or neglect was to cease immediately. S#218 has continued to demonstrate a pattern of performance concerns in relation incidents of staff to resident abuse and/or neglect.

Supporting documentation from the CO issued on February 19, 2015, outlined that in S#218's personnel file, there were numerous memos from other staff members outlining concerns relative to S#218's conduct towards residents. As well, several "Notice of Action Required Forms" were filed with respect to staff S#218's improper conduct. As mentioned, this staff member received numerous disciplinary actions, and a memo from the Director of Care indicated that repeat incidents would result in termination.

(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 14, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 14th day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tiffany Boucher

Service Area Office /
Bureau régional de services : Sudbury Service Area Office