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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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 2, 2016	2016_425639_0004	002363-16	Complaint

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

JESSICA WASYLENKI-RYAN (639)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 12-15, 2016

This Complaint inspection is related to medication administration, bathing, and laundry services.

A Complaint inspection related to air temperature and failure to report alleged abuse was conducted concurrently with this inspection. For details see inspection #2016_483637_0004.

A Complaint inspection related to improper care, abuse and neglect of a resident and retaliation was conducted concurrently with this inspection. For details see inspection 2016_429642_0003.

A Critical Incident inspection related to an unexpected death was conducted concurrently with this inspection. For details, see inspection #2016_483637_0005.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), Laundry Services Worker, resident family member(s) and resident(s).

During the course of the inspection, the inspector reviewed resident clinical records, resident plan of care, various policies and procedures, and made observations of the residents and their environment.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (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 the resident as specified in the plan.

A complaint was received by the Director on January 19th, 2016. The complaint stated that resident #001 had not been receiving a topical treatment ordered by the physician for pain management.

The care plan for resident #001 indicated that the resident experienced pain.

A review of the physician order for resident #001 indicated that the physician prescribed a topical analgesic.

A review of the Cream Application Record (CAR) for January, and February 2016, indicated that the treatment for resident #001 had not been provided consistently. On 34 occasions between January 07, 2016 and February 27, 2016, the resident did not have the cream applied twice daily as ordered by the physician.

A review of the home's Policy and Procedure titled Skin and Wound Care - Cream Application last reviewed February 10, 2012, indicated that HCAs are to sign the CAR once the prescribed cream had been applied.

In an interview, RPN #106 stated that it was the expectation of the home that topical creams and gels were to be signed for like all other medications. RPN #106 confirmed that a medication without a signature indicated that it had not been administered to the resident.

In an interview, the DOC confirmed that if a medication was not signed for, it had not been given. The DOC stated that an audit of the CARs indicated that treatments were not being provided as prescribed in the Physician's order. [s. 6. (7)]

Issued on this 3rd day of May, 2016

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

Original report signed by the inspector.