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 prévue le Loi de 2007 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 soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Nov 22, 2016;	2016_320612_0020 (A1)	017974-16	Resident Quality Inspection

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

Ontario

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Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date extension requested by the Administrator, approved for December 14, 2016.

Issued on this 22 day of November 2016 (A1)

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

Original report signed by the inspector.

Ontario

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SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 4-8 and 11-15, 2016

During the inspection, the Inspectors also inspected five Critical Incidents (CI) related to abuse of residents, two CIs related to falls, and two complaints related to the care of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Coordinator, Maintenance Staff, Human Resource Manager, Manager of Environmental Services, Infection Control Coordinator, Registered Dietitian (RD), Cook, Dietary Aide, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to residents interactions, reviewed residents' health care records, staffing schedules, staff training records, policies, procedures, programs, and staff personnel files.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Safe and Secure Home

Skin and Wound Care

Snack Observation

Sufficient Staffing

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

- **8 WN(s)**
- **4 VPC(s)**
- **1 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the organized program of personal support services for the home met the assessed needs of the residents.

a) On a day in July, 2016, resident #034 approached Inspector #612, #627 and #639 and reported that the home was often short staffed, and on that specific day, they had waited 45 minutes for someone to assist them to the washroom. They stated that they were unable to get themselves to the washroom. They reported that they then waited 14 minutes for someone to assist them out of the washroom. They reported that PSW #120 was the staff member assisting them and told the resident that they were short on the floor.

On another day in July, 2016, Inspector #612 observed that resident #034's call bell was ringing for 15 minutes. The Inspector approached the resident's room and observed that the resident was in the washroom and calling for assistance. After staff assisted the resident in the washroom, the resident stated to the Inspector that it took staff a long time to assist them.

The Inspector interviewed the PSW #120 who stated that they were short staffed that morning and they were doing their best to assist residents as quickly as possible.

The Inspector reviewed correspondence provided by a staff member which stated that the home was short one PSW on resident #034's unit on the two dates in July, 2016.

b) On a day in July, 2016, resident #023 approached Inspector #612, #627 and #639. They stated that the home routinely had staffing shortages, specifically, the home was short PSWs. They reviewed documentation with Inspector #627 which indicated that they had to wait an excessive amount of time over a specified period of time for assistance with toileting on a specific number of shifts. According to the documentation, they had to wait in excess of 30 minutes on 36 shifts between March, 2016 and July, 2016.

On another day in July, 2016, Inspector #612 interviewed the home's DOC who stated that they were currently hiring PSWs to work in the home. The staffing plan was based on the staff's feedback as well as the resident's Case Mix Index, which indicated the level of care residents required. The DOC stated that 12 minutes was a reasonable amount of time for staff to answer a call bell to assist residents and with toileting, it was expected that staff responded as soon as possible.

c) During the course of the RQI, Inspector #612 did not observe a between meal beverage being offered to residents in the morning, after breakfast on July 6, 7, and 8, 2016.

During an interview with resident #027's family member, they mentioned that residents were not offered a minimum of a between-meal beverage in the morning. Staff told the family member that they did not have enough time. During stage one of the RQI, resident #001, #002, #004, #009, #025 and #026 stated during resident interviews that the home did not offer a minimum of a between-meal beverage in the morning.

The Inspector interviewed PSW #122 and #123 who confirmed that residents were not offered a minimum of a between-meal beverage in the morning as the staff did not have enough time.

The Inspector interviewed the Dietitian who stated that the staff were expected to offer the resident's a minimum of a between-meal beverage in the morning but stated that they often did not have enough time.

The Inspector interviewed the DOC who confirmed it was the expectation that the PSW's offered the resident's fluids in the morning, between breakfast and lunch.

d) On a day in July, 2016, Inspector #612 observed a dining service on a specific unit. The Inspector arrived at 1205 hours, lunch started at 1200 hours. The Inspector observed that the independent residents were served their food first. There were a number of residents identified on the seating chart who required total assistance of one staff member for eating and another number of residents that required supervision or occasional assistance. Two staff members came from other units and provided total assistance with eating and drinking to two residents, at 1215 hours. There were also family members assisting residents. There was a number of residents who required the total assistance of one staff member for eating that waited in the dining room for 40 minutes prior to being served once a staff member was available. Resident #033 was agitated, and staff continued to state to the resident that the food was coming as soon as someone was available to help.

During an interview with resident #031's family member, they stated the unit was always short of staff and that the residents who required assistance may not get to

eat right away, therefore they came in every day to feed resident #031.

During an interview with a family member of resident #032, they stated that they came in daily to feed resident #032 and check on them. They stated that the unit was short staffed on a daily basis.

e) On a day in July, 2016, at 1100 hours, Inspector #612 observed a staff member preparing a breakfast tray for resident #035. The staff member stated to the Dietary Aide that the resident was not assisted out of bed that morning for breakfast.

The Inspector interviewed PSW #120 who stated that they forgot about resident #035 this morning as they were short staffed. They confirmed that another staff member had assisted the resident with eating.

Inspector #612 interviewed the DOC and they confirmed that the staff were expected to complete all essential care that the residents required during their shift. [s. 8. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

During stage one of the RQI, resident #012 was identified as being at risk for dehydration.

On a day in July, 2016, Inspector #627 observed that resident #012 was not in the dining room during a meal service. The Inspector entered the resident's room and asked the resident if they wanted to have lunch, and the resident stated yes. The Inspector notified RPN #133 and the resident was taken to the dining room.

On another day in July, 2016, Inspector #612 observed that resident #012 was not served their food until 30 minutes after the staff started serving the meal. The resident then sat with the food in front of them for 30 minutes, when the staff brought the resident back to their room, without eating. No staff offered encouragement to the resident to eat their food. The Inspector noted on the food intake sheet that the resident had refused their two prior meals.

On another day in July 2016, Inspector #627 observed resident #012’s room for an hour and noted that no staff had entered the room to encourage the resident to attend meal service.

Inspector #627 interviewed PSW #132, and they stated that the resident had refused to go to the meal service. PSW #132 stated that they were to provide a supplement when the resident refused a meal, however, they were unsure if it was provided. When the Inspector and PSW verified that the resident had not been provided with the supplement, the PSW provided it to the resident.

A review of the resident's most recent care plan included specific interventions related to staff encouraging the resident to attend meals, providing items that the resident enjoyed and providing a supplement when the resident refused.

During an interview with the Inspector, the DOC confirmed that care was not provided to resident #012 as per the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the following was documented: 2. The outcomes of the care set out in the plan of care.

During stage one of the RQI, resident #012 was identified through the RAI/MDS as being at moderate risk of dehydration.

During an interview with Inspector #627, the Registered Dietitian (RD) stated that when a resident was identified at moderate risk of dehydration, accurate documentation was required for fluid intake. This included staff completing three specific forms: "Fluid Intake for Medication Pass from RPNs", "Main Meal Intake Record", and "Nourishment Intake Record".

Inspector #627 and the RD reviewed the "Fluid Intake for Medication Pass for RPN" form, for a specific period of time in July 2016, and noted that a line was drawn through all fields of the documentation on one of the days, and the morning and noon med passes on another date. There was nothing documented for the supper and bedtime medication passes.

Inspector #627 and the RD reviewed the "Main Meal Intake Record" form, for a specific period of time in July 2016, and noted that there was no documentation for breakfast on six of the days, no documentation for lunch on four of the dates, and no documentation for supper on three of the dates.

Inspector #627 and the RD reviewed the "Nourishment Intake Record" form, for a specific period of time in July 2016, and noted that on a specific date, there was no beverage intake documented. The Inspector and RD were unable to locate the record for three other days.

A review of the policy titled, "Dietary Services Manual, Section Nutrition: Document number, 05-01026", dated August, 2014, revealed that, accurate documentation was required for food/fluid records.

The RD confirmed that resident #012's fluid intake had not been accurately documented and should have been. [s. 6. (9) 2.]

3. The licensee has failed to ensure that when the resident was reassessed, the plan of care was reviewed and revised when the resident's care needs changed.

During stage one of the RQI, resident #022 was identified through a staff interview as having experienced a fall within the past 30 days.

Inspector #612 reviewed the resident's health care record and noted that the resident had experienced a fall in July, 2016.

The Inspector reviewed the resident's most recent care plan and noted that the resident was identified as being at high risk for falls. There were interventions identified in their care plan.

The Inspector noted that the resident had experienced a fall in March 2016. RN #126 had completed the post fall summary and indicated as part of the plan to minimize further falls, a specific intervention was to be implemented.

The Inspector interviewed PSW #122 and #123 who confirmed that they had implemented the specific intervention identified, after the residents fall in March, 2016.

The Inspector interviewed RN #110 who confirmed that the specific intervention identified, should have been added to their care plan. RN #110 confirmed that the care plan had not be updated when the resident's care needs changed. [s. 6. (10) (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 #012 receives the specific interventions as set out in their plan of care and the outcome is documented and that resident #022's plan of care is reviewed and revised when their care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

During stage one of the RQI, resident #022 was identified during a staff interview as having had a fall within the last 30 days.

Inspector #612 reviewed resident #022's health care record and noted that the resident had a fall on a day in July, 2016, March, 2016, and November, 2015. A post fall summary was completed by registered staff three months after the fall that occurred in November, 2015, and six weeks after the fall which occurred in March, 2016.

The Inspector reviewed the home's policy titled, "Falls Prevention and Management", last revised May 7, 2016, which indicated that the RN was responsible to complete a post fall summary ten to fourteen days after a fall to assess for further action and intervention effectiveness.

The Inspector interviewed RN #110 who stated that the expectation was that the post fall summary was completed ten to fourteen days after a resident's fall, and confirmed that it was not completed for resident #022's fall in November, 2015, until approximately three months later, and the fall in March, 2016, until approximately six weeks later. [s. 8. (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 the home's policy titled, "Falls Prevention and Management," last revised May 7, 2016, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

During stage one of the RQI, resident #016 was identified as having had a change in continence.

The RAI-MDS assessment indicated that resident #016 was incontinent.

Inspector #639 reviewed resident #016's health record and was unable to locate an incontinence assessment that included causal factors, patterns, type of incontinence, and potential to restore function with specific interventions, using a clinically appropriate assessment instrument specifically designed for the assessment of incontinence.

A review of the home's policy titled, "Continence Management Program's Bowel/Bladder Assessment," dated May 4, 2015, indicated the following,
1. screening resident for continence level occurs on admission and quarterly using the RAI-MDS assessment, upon significant change in status relating to continence.
2. resident voiding and bowel patterns are assessed on admission using the Continence Assessment Form.
3. registered staff completes the continence assessment with all residents/POA on admission.

In an interview, the RAI/MDS Coordinator stated to Inspector #639 that all residents were to have a continence assessment completed upon admission to the home, and with any significant change in continence level and that there was no continence assessment done for resident #016. [s. 51. (2) (a)]

2. During stage one of the RQI, resident #014 was identified as having had a change in their continence.

Inspector #639 reviewed resident #014's health record which indicated that they were admitted to the LTCH on a specific date. A "Bowel/Bladder Assessment – Continence Assessment Form", was completed on admission and indicated that resident #014 was continent of bladder.

Inspector #639 reviewed the residents RAI-MDS completed within a week of their admission date, which indicated that resident #014 was usually continent with incontinent episodes occurring once a week or less. The RAI-MDS assessment completed two months later, identified that resident #014’s was incontinent. The Inspector was unable to locate an assessment that included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument specifically designed for the assessment of incontinence.

A review of the home's policy titled, "Continence Management Program's Bowel/Bladder Assessment," dated May 4, 2015, indicated that residents were assessed for their continence status on admission, quarterly and whenever there was a change in health status that affected bowel and bladder function.

In an interview, the RAI/MDS Coordinator stated that resident #014 had not had a assessment that included the identification of causal factors, patterns, type of

incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument specifically designed for the assessment of incontinence. [s. 51. (2) (a)]

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 #016, #014 and all other residents who are incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

a) During stage one of the RQI, resident #001, #002, #004, #009, #025, and #026 stated during resident interviews that the home did not offer a minimum of a between-meal beverage in the morning. Resident #012 was identified through the RAI-MDS as a moderate risk for dehydration.

During an interview with Inspector #627, PSW #121 stated that there were no beverages offered regularly, although resident #012 would sometimes get water during morning care. PSW #121 further stated that beverages were distributed to residents only when time permitted; therefore, resident #012 was not given a beverage between breakfast and lunch.

b) During an interview with resident #027's family member, they mentioned that the residents were not offered a minimum of a between-meal beverage in the morning. Staff had told the family member that they did not have enough time.

Inspector #612 did not observe a between meal beverage being offered to residents in the morning, after breakfast on July 6, 7, and 8, 2016.

Inspector #612 interviewed PSW #122 and #123 who confirmed that residents were not offered a minimum of a between-meal beverage in the morning as the staff did not have enough time.

Inspector #612 interviewed the Registered Dietitian (RD) who stated that the staff were expected to offer the residents a minimum of a between-meal beverage in the morning, but stated that they often did not have enough time.

Inspector #612 interviewed the DOC who confirmed it was the home's expectation that the PSW's offer the residents fluids in the morning, between breakfast and lunch. [s. 71. (3) (b)]

2. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

During the course of the inspection, a family member of resident #027 stated that food items often ran out or were not even offered.

Inspector #612 observed the dining service on the evening of July 11, 2016, and noted that there was no creamed corn available and corn kernels were being

served.

The Inspector interviewed Cook #137 who stated that they were to have creamed corn for the residents who required a minced texture but they did not have any. Cook #137 stated that the residents with a minced texture would be served the other vegetable, which was mixed vegetables.

The Inspector interviewed the Food Services Manager who stated that there was no excuse to explain why the creamed corn was not prepared for the residents who required a minced texture. [s. 71. (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 residents are offered a minimum of a between meal beverage in the morning, afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #612 reviewed a Critical Incident (CI) report which indicated that resident #018 exhibited a specific sexual behaviour towards resident #017. The home notified the Director one day after the incident and the CI was submitted five days later.

The Inspector reviewed the investigation notes provided by the DOC which indicated that RN #141 notified the DOC the morning after the incident, and advised that the family had been notified and had no concerns. The residents family member came in later in the evening and expressed concerns about the incident. The DOC was called again by RN #141 and advised to notify the Director about the incident.

The Inspector interviewed the DOC who stated that the Director was notified the day after the incident as the staff were concerned about the reaction of resident #017's family member. The DOC was not concerned about the actions of resident #018 as they had never exhibited sexual behaviours like that before. [s. 24. (1)]

2. Inspector #627 reviewed a CI report which was submitted to the Director on a specific date and alleged that an incident occurred between a resident and their family member.

A review of the CI revealed that the alleged incident occurred the day before it was reported to the Director.

During an interview with the Inspector, RN #138 stated that they had not reported the incident immediately.

No further action will be taken in regards to this non-compliance as there is currently an outstanding compliance order related to s. 24. (1). from Complaint Inspection #2016_483637_0004. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident received assistance, if required, to use personal aids.

During stage one of the RQI, resident #001 was identified through the RAI-MDS for a lack of corrective action for a communication problem.

On July 6, 7, and 8, 2016, Inspector #627 observed resident #001 without a specific assistive device.

A review of the most recent written care plan revealed that the resident required help with the assistive device.

During an interview with the Inspector, PSW #108 stated that resident #001 had used the assistive device in the past, however the registered staff usually helped residents with the assistive devices.

During an interview with the Inspector, RPN #109 stated that when residents required assistance with the assistive device, it was entered in the system to prompt the registered staff. RPN #109 was unable to find an entry to indicate that the resident required assistance with the assistive device.

During an interview with resident #001, the resident stated to the Inspector and RPN #109, that they required help with the assistive device.

During an interview with the RAI-MDS Coordinator, they stated that if a resident was unable to independently use the assistive device, an entry was made in the system to prompt the registered staff to apply the assistive device. The RAI-MDS Coordinator confirmed the resident should have received help with the assistive device and this was not done. [s. 37. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, the symptoms were recorded and that immediate action was taken as required.

During stage one of the RQI, resident #007 was identified as having had an infection.

Inspector #627 reviewed resident #007's health care record which revealed a Doctor's note that indicated that on a specific day, the resident had exhibited symptoms related to an infection and required isolation.

A review of the progress notes revealed that resident #007 was placed in isolation on a specific date and the resident had exhibited symptoms two days later. The date that the resident was removed from isolation was not noted. There were no other progress notes documenting the residents symptoms during this time.

A review of the documented vital signs in "Gold Care" revealed that vital signs were taken on the specific dated when the resident was placed in isolation and nothing after.

During an interview with RN #136, they stated that a resident was to be monitored on every shift when in isolation. This monitoring included vital signs and an assessment of the residents symptoms. The vital signs were recorded in "Gold Care" by the PSW, and were reported to the registered staff. RN #136 confirmed that vital signs and an assessment of the residents symptoms should have been completed and documented for every shift resident #007 was in isolation, and this was not done. [s. 229. (5) (b)]

Issued on this 22 day of November 2016 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SARAH CHARETTE (612) - (A1)

Inspection No. / No de l'inspection : 2016_320612_0020 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 017974-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Nov 22, 2016;(A1)

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

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

Ministère 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jacques Dupuis

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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)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the organized program of personal support services of the home meets the assessed needs of the residents, including, but not limited to the following:

a) Ensure that resident #023, #034, and all residents receive the assistance required with toileting in a timely manner;

b) Ensure that all residents within the home receive a between meal beverage in the morning, after breakfast; and

c) Ensure that residents #031, #032, #033, #035, and all residents within the home receive their meal and assistance to eat their meal in a timely manner; despite staff shortages within the home.

Grounds / Motifs :

1. The licensee has failed to ensure that the organized program of personal support services for the home met the assessed needs of the residents.

a) On a day in July, 2016, resident #034 approached Inspector #612, #627 and #639 and reported that the home was often short staffed, and on that specific day, they had waited 45 minutes for someone to assist them to the washroom. They stated that they were unable to get themselves to the washroom. They reported that they then waited 14 minutes for someone to assist them out of the washroom. They reported that PSW #120 was the staff member assisting them and told the resident that they were short on the floor.

On another day in July, 2016, Inspector #612 observed that resident #034's call bell was ringing for 15 minutes. The Inspector approached the resident's room and observed that the resident was in the washroom and calling for assistance. After staff assisted the resident in the washroom, the resident stated to the Inspector that it took staff a long time to assist them.

The Inspector interviewed the PSW #120 who stated that they were short staffed that morning and they were doing their best to assist residents as quickly as possible.

The Inspector reviewed correspondence provided by a staff member which stated that the home was short one PSW on resident #034's unit on the two dates in July, 2016.

b) On a day in July, 2016, resident #023 approached Inspector #612, #627 and #639. They stated that the home routinely had staffing shortages, specifically, the home was short PSWs. They reviewed documentation with Inspector #627 which indicated that they had to wait an excessive amount of time over a specified period of time for assistance with toileting on a specific number of shifts. According to the documentation, they had to wait in excess of 30 minutes on 36 shifts between March, 2016 and July, 2016.

On another day in July, 2016, Inspector #612 interviewed the home's DOC who stated that they were currently hiring PSWs to work in the home. The staffing plan was based on the staff's feedback as well as the resident's Case Mix Index, which indicated the level of care residents required. The DOC stated that 12 minutes was a reasonable amount of time for staff to answer a call bell to assist residents and with

toileting, it was expected that staff responded as soon as possible.

c) During the course of the RQI, Inspector #612 did not observe a between meal beverage being offered to residents in the morning, after breakfast on July 6, 7, and 8, 2016.

During an interview with resident #027's family member, they mentioned that residents were not offered a minimum of a between-meal beverage in the morning. Staff told the family member that they did not have enough time. During stage one of the RQI, resident #001, #002, #004, #009, #025 and #026 stated during resident interviews that the home did not offer a minimum of a between-meal beverage in the morning.

The Inspector interviewed PSW #122 and #123 who confirmed that residents were not offered a minimum of a between-meal beverage in the morning as the staff did not have enough time.

The Inspector interviewed the Dietitian who stated that the staff were expected to offer the resident's a minimum of a between-meal beverage in the morning but stated that they often did not have enough time.

The Inspector interviewed the DOC who confirmed it was the expectation that the PSW's offered the resident's fluids in the morning, between breakfast and lunch.

d) On a day in July, 2016, Inspector #612 observed a dining service on a specific unit. The Inspector arrived at 1205 hours, lunch started at 1200 hours. The Inspector observed that the independent residents were served their food first. There were a number of residents identified on the seating chart who required total assistance of one staff member for eating and another number of residents that required supervision or occasional assistance. Two staff members came from other units and provided total assistance with eating and drinking to two residents, at 1215 hours. There were also family members assisting residents. There was a number of residents who required the total assistance of one staff member for eating that waited in the dining room for 40 minutes prior to being served once a staff member was available. Resident #033 was agitated, and staff continued to state to the resident that the food was coming as soon as someone was available to help.

During an interview with resident #031's family member, they stated the unit was

always short of staff and that the residents who required assistance may not get to eat right away, therefore they came in every day to feed resident #031.

During an interview with a family member of resident #032, they stated that they came in daily to feed resident #032 and check on them. They stated that the unit was short staffed on a daily basis.

e) On a day in July, 2016, at 1100 hours, Inspector #612 observed a staff member preparing a breakfast tray for resident #035. The staff member stated to the Dietary Aide that the resident was not assisted out of bed that morning for breakfast.

The Inspector interviewed PSW #120 who stated that they forgot about resident #035 this morning as they were short staffed. They confirmed that another staff member had assisted the resident with eating.

Inspector #612 interviewed the DOC and they confirmed that the staff were expected to complete all essential care that the residents required during their shift.

There is no previous history of related non-compliance.

There decision to issued this compliance order is based on the severity, which is a potential for actual harm and the scope, which is pattern throughout the home. (612)

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

Dec 14, 2016(A1)

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
Long-Term Care Inspections 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

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

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 22 day of November 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAH CHARETTE - (A1)

Service Area Office /
Bureau régional de services : Sudbury