Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Melissa Chisholm	**Inspector ID #**	188
Log #:	S-00806, IL-15868-SU S-00705, IL-15575-SU S-00663, IL-15376-SU		
Inspection Report #:	2011_188_9502_05Apr143623		
Type of Inspection:	Complaint		
Date of Inspection:	April 6, 2011		
Licensee:	The Board of Management of the District of Nipissing West, 100 Michaud Street, Sturgeon Falls ON P2B 2Z4 Fax: 705-753-1550		
LTC Home:	Au Chateau, 100 Michaud Street, Sturgeon Falls ON P2B 2Z4, Fax: 705-753-3135		
Name of Administrator:	Jacque Dupuis		

To the Board of Management of the District of Nipissing West, you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA, 2007, S.O. 2007, c.8, s.3(1)14 Every licensee of a long-term care home shall ensure that the following rights of a resident are fully respected and promoted: #14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

Order:

The licensee shall ensure that the rights of residents to receive visitors of his or her choice are fully respected and promoted at all times including periods of infectious outbreaks, unless directed otherwise by order of the Public Health Unit.

Grounds:

The licensee failed to allow residents to receive visitors of his or her choice since March 3, 2011, during an outbreak, as noted in the following findings of the inspector:

1. Inspector observed upon entrance to the home April 6, 2011 that the second set of doors in the entrance to the facility were locked and a large red sign was posted stating "No visitors beyond this point. Aucun visiteur au dela de ce point". Also posted in the front entrance an orange sign that stated "Attention visitors. Due to an outbreak the general public is NOT ALLOWED in the home for

an indefinite period of time. Are allowed in: 1) Authorized primary care givers. 2) Persons visiting a resident in palliative care. Thank you for your cooperation 'Au Chateau' Administration".

2. Inspector spoke with the public health nurse assigned to the home in regards to the outbreak who indicated that no restriction on visitation has been issued to the home. The public health nurse indicated that the home is encouraged to educate and screen visitors and limit visitation to one resident at a time.
3. Inspector interviewed the Director of Care and the Infection Control Nurse who confirmed that the home is not allowing visitors unless they are authorized "partners in care" or the resident is palliative. All other visitors are being turned away from the home during an outbreak.
4. Inspector reviewed the document titled "Outbreak Control Measures" received by the home from the public health unit on March 3, 2011 when the outbreak was declared. In respect to visitation it identifies, "notify visitors of potential risk within the facility (e.g. Post signage)" and "Educate visitors re: precautions (e.g. Post signage and/or all visitors to report to reception)". No direction to prevent visitors from entering the home and visiting with residents was noted.
5. Inspector spoke with two family members of residents within the home who identified themselves as "partners in care" and confirmed that other family members are not permitted to enter the home and visit during the outbreak.
6. Inspector spoke with the receptionist who confirmed that unless the visitor is a "partner in care" identified on the list of authorized visitors they are not permitted to enter the home during the outbreak.
7. Inspector observed on April 6, 2011 at 1115h a member of the public attempt to enter the home and was turned away at the reception desk because they were not an identified "partner in care".

This order must be complied with by:	Immediately

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 7th day of April, 2011.	
Signature of Inspector:	
Name of Inspector:	Melissa Chisholm
Service Area Office:	Sudbury

Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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 603
Sudbury ON P3E 6A5

Telephone: 705-564-3130
Facsimile: 705-564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
Sudbury ON P3E 6A5

Téléphone: 705-564-3130
Télécopieur: 705-564-3133

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
April 6, 2011	2011_188_9502_05Apr143623	Complaint S-00806, IL-15868-SU S-00705, IL-15575-SU S-00663, IL-15376-SU

Licensee/Titulaire
The Board of Management of the District of Nipissing West, 100 Michaud Street, Sturgeon Falls ON P2B 2Z4
Fax: 705-753-1550

Long-Term Care Home/Foyer de soins de longue durée
Au Château, 100 Michaud Street, Sturgeon Falls ON P2B 2Z4, Fax: 705-753-3135

Name of Inspector/Nom de l'inspecteur
Melissa Chisholm #188

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: the Director of Care (DOC), the Infection Control Nurse, the receptionist, Registered Staff members, Personal Support Workers (PSW), a nurse from the public health unit, residents and family members of residents.

During the course of the inspection, the inspector: conducted a walk through of resident rooms and various common areas, observed infection control practices of staff, reviewed the home's policies related to infection control and outbreak measures and reviewed the staffing plan and staffing schedules.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Sufficient Staffing

Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN
1 CO: CO # 001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 3(1)14 Every licensee of a long-term care home shall ensure that the following rights of a resident are fully respected and promoted: #14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

Findings:
The licensee failed to allow residents to receive visitors of his or her choice since March 3, 2011, during an outbreak, as noted in the following findings of the inspector:

1. Inspector observed upon entrance to the home April 6, 2011 that the second set of doors in the entrance to the facility were locked and a large red sign was posted stating "No visitors beyond this point. Aucun visiteur au dela de ce point". Also posted in the front entrance an orange sign that stated "Attention visitors. Due to an outbreak the general public is NOT ALLOWED in the home for an indefinite period of time. Are allowed in: 1) Authorized primary care givers. 2) Persons visiting a resident in palliative care. Thank you for your cooperation 'Au Chateau' Administration".

2. Inspector spoke with the public health nurse assigned to the home in regards to the outbreak who indicated that no restriction on visitation has been issued to the home. The public health nurse indicated that the home is encouraged to educate and screen visitors and limit visitation to one resident at a time.

3. Inspector interviewed the Director of Care and the Infection Control Nurse who confirmed that the home is not allowing visitors unless they are authorized "partners in care" or the resident is palliative. All other visitors are being turned away from the home during an outbreak.

4. Inspector reviewed the document titled "Outbreak Control Measures" received by the home from the public health unit on March 3, 2011 when the outbreak was declared. In respect to visitation it identifies, "notify visitors of potential risk within the facility (e.g. Post signage)" and "Educate visitors re: precautions (e.g. Post signage and/or all visitors to report to reception)". No direction to prevent visitors from entering the home and visiting with residents was noted.

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7. Inspector observed on April 6, 2011 at 1115h a member of the public attempt to enter the home and was turned away at the reception desk because they were not an identified "partner in care".

Inspector ID #:	188

Additional Required Actions:

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

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). April 7, 2011