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 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 soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 11, 2019	2018_752627_0025	010383-18, 016788-18, 020849-18, 025070-18, 025961-18, 026114-18	Critical Incident System

Licensee/Titulaire de permis

Board of Management for 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

SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 5-9, 13-16 and 19-23, 2018.

A Follow Up Inspection # 2018_752627_0024 and a Complaint Inspection # 2018_752627_0023 were completed concurrently with this Critical Incident System Inspection. PLEASE NOTE: Two written notifications and Compliance Order (CO) related to LTCHA, 2007, s. 6 (7) were identified in this Inspection and have been issued in Inspection Report #2018_752627_0024.

The following intakes were completed in this Critical Incident Inspection:

- One critical incident related to missing narcotics;
- Two critical incidents related to neglect;
- One critical incident related to falls; and,
- Two critical incidents related to alleged resident to resident abuse.

Inspector, Steven Naccarato (#744) attended this Inspection in addition to Inspector #627.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Coordinator of Resident Services (CRS), Environmental Service Manager (ESM), Dietary Manager (DM), Physiotherapist (PT), Pastoral Care, Physiotherapist assistants (PTAs), Dietary Aides (DAs), Housekeeping staff (HS), Pharmacy Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and families.

The inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigations, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	Légende 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 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Ontario Regulation (O.Reg.) 79/10, section (s.) 114 (1) of the Long-Term Care Homes Act (LTCHA), indicates that "the license shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home".

A critical incident system (CIS) report was submitted to the Director indicating that resident #012's medication patch went missing. The CIS report indicated that when Registered Practical Nurse (RPN) #127 proceeded to apply a new medication patch, they could not find the old patch.

Inspector #627 reviewed the home's policy, related to a medicated patch drug destruction, last updated 2018, which indicated that at shift change, the staff member was required to sign off on the medication patches to indicate that they, and a fellow registered staff member, had physically seen the patch on the resident.

Inspector #627 interviewed RPN #125, who stated that the home's policy was to complete a count of specific medications at the beginning and at the end of every shift, with the oncoming and outgoing registered staff member. RPN #125 stated that they had not known that the two staff members were to ensure that the medication patches were on the residents during the count of the specific medications. They further stated that they had not been made aware of this policy, nor was it practiced by other RPNs, at the time of the incident.

Inspector #627 interviewed RPN #124 who stated that they had been working at the time of the alleged incident. RPN #124 stated that they had not ascertained that resident #012's medication patch was on them as the resident had been sleeping at the beginning of their shift, and remained asleep when they had left for the day.

Inspector #627 interviewed the Director of Care (DOC) who acknowledged that the staff had not followed the home's policy by not checking that the medication patch was on the resident at the beginning and at the end of the shift, during the specific medication count. [s. 8. (1) (b)]

Issued on this 29th day of January, 2019

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

Original report signed by the inspector.