Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 11, 2020	2020_805638_0005	023639-19	Complaint

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

RYAN GOODMURPHY (638), SHELLEY MURPHY (684)

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): January 29 - 31 and February 3 - 5, 2020.

The following intake was completed in this complaint inspection:
-One log was a complaint submitted to the Director regarding resident care, sufficient staffing and fall management.

A critical incident system inspection #2020_805638_0006 was conducted concurrently with this complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist, Physiotherapy Assistant, a physician, residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs and resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were bathed, at a minimum, twice a

week by the method of their choice.

A complaint was submitted to the Director regarding resident care concerns and staffing levels affecting resident care. Inspector #684 reviewed the care provided to resident #001 and resident #003 related to the complaint that was submitted to the Director regarding resident care concerns.

Inspector #684 reviewed a documentation report for resident #001 and noted the resident missed their scheduled bath on one specific date in December 2019. The January 2020, documentation showed that the resident missed their scheduled bath on another specific date, which meant the resident did not have a bath for 10 consecutive days. The Inspector noted that the resident also missed their bath on two other specific dates where the resident went another eight consecutive days without a bath. Upon review of the care plan for resident #001, it stated the resident was scheduled for a bath twice weekly.

Inspector #684 reviewed the documentation report for resident #003, which showed in December 2019, three scheduled baths were missed and in January 2020, three scheduled baths were missed, which caused the resident to go six days without a bath in each instance.

Inspector #684 reviewed the documentation report for resident #007, which showed in December 2019, the resident was not given two of their scheduled baths, which resulted in the resident going 10 days without a bath and in January 2020, the documentation record identified two scheduled baths were missed.

Inspector #684 reviewed the electronic progress notes from Point Click Care (PCC) for residents #001, #003, and #007 from December 2019, to February 2020, there were no notes to indicate that any of the identified residents refused or were unavailable for their scheduled baths.

Inspector #684 interviewed PSW #114, #119 and #120 who all indicated that the bath/shower schedule was kept on PCC and this identified which residents were due for their bath/shower on each shift. The PSWs also indicated that baths/showers that were given were to be documented on Point of Care (POC) electronic charting. Inspector #684 asked what occured should a resident refuse their bath/shower, the PSWs indicated that they were to put “Activity did not occur” or they left the record blank in POC charting so that when they reviewed the outstanding baths/shower they knew which residents did not

receive their bath/shower, and they were to make a progress note in PCC. Inspector #684 reviewed with PSW #114, #119 and #120 the documentation report, which showed numerous blanks under bathing for resident #001, #003 and #007. Each PSW indicated that there should not be blanks in the charting and a blank would indicate that the bath/shower was not provided. The PSWs indicated that each day a priority list was created for the outstanding baths/showers that did not get completed on the previous day. PSW #114 and #119 both indicated sometimes they were so far behind on bath/showers they scrap the priority list and start over, which indicated that some residents missed their scheduled bath/shower.

During an interview with RN #115 they indicated to Inspector #684, that they do fall behind on baths due to short staffing and unless they call in someone they may end up back at the start of the bath/shower schedule and never catch up.

Inspector #684 interviewed the DOC, who indicated that the current process for bathing/showering residents was not working. Inspector #684 reviewed the documentation report for resident #001, #003 and #007 with the DOC. Upon review, they acknowledged that the residents did miss baths/showers that were scheduled and the baths/showers were to be given as scheduled and prioritized. The DOC stated, “a resident going ten days without a bath/shower was unacceptable”. [s. 33. (1)]

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 each resident is bathed, at a minimum, twice a week by the method of their choice, to be implemented voluntarily.

Issued on this 12th day of February, 2020

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

Original report signed by the inspector.