Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 12, 16, Oct 12, Nov 1, 22, 23, 2011	2011_050151_0007	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

MONIQUE BERGER (151)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with
- Administrator
- Director of Care
- Registered Staff
- Personal Support Workers (PSW)
- Resident

During the course of the inspection, the inspector(s)
- walk-through of the home and of the resident's room,
- toured the medication rooms and storage areas where medications are kept,
- observed direct care and service to residents,
- reviewed the resident's health care record,
- reviewed relevant home policies,
- reviewed DOC memos relating to the issues identified,

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Medication

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Personal Support Services

Resident Charges

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. *****The licensee has failed to ensured that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time[O.Reg.79/10, s. 124.]

A resident ran out of a medication and was given another resident's medication to use while staff ordered more for the resient. This was confirmed by interviews with the resident and staff and by a progress note in the resident's health care record.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. *****The home has not ensured that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [r. 131. (2)]

A resident was administered a medication that was not in accordance with the directions for use specified by the prescriber. A resident ran out of a medication and was given another resident's medication to use while staff ordered more for the resident. This was confirmed by interviews with the resident and staff and by a progress note in the resident's health care record. Staff interviewed confirmed that it was not unusual for the home to borrow from another resident if they ran out of medication for a resident.

Issued on this 23rd day of November, 2011

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

Monique Berger (151)