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 sous la Loi de 2007 sur les foyers de soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 13, 2013	2013_138151_0007	S-001381-12	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.

This inspection was conducted on the following date(s): February 19,20,21, 2013

This inspection relates to the following:
- S-001375-12 related to IL 25880-SU
- S- 001381-12 related to Critical Incident: M502-000034-12
- S- 001381-12 related to Critical Incident: M502-000033-12

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

During the course of the inspection, the inspector(s)
- directly observed care and services to residents
- reviewed the home's related policies and procedures
- reviewed the home 's program on management of responsive behaviours
- reviewed the home's medication administration systems and related policies
- reviewed the resident's health care records

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Medication

Minimizing of Restraining

Personal Support Services

Responsive Behaviours

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. 137. Restraining by administration of drug, etc., under common law duty

Specifically failed to comply with the following:

s. 137. (2) Every licensee shall ensure that every administration of a drug to restrain a resident when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in section 36 of the Act is documented, and without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. Circumstances precipitating the administration of the drug. O. Reg. 79/10, s. 137 (2).
2. Who made the order, what drug was administered, the dosage given, by what means the drug was administered, the time or times when the drug was administered and who administered the drug. O. Reg. 79/10, s. 137 (2).
3. The resident's response to the drug. O. Reg. 79/10, s. 137 (2).
4. All assessments, reassessments and monitoring of the resident. O. Reg. 79/10, s. 137 (2).
5. Discussions with the resident or, where the resident is incapable, the resident's substitute decision-maker, following the administration of the drug to explain the reasons for the use of the drug. O. Reg. 79/10, s. 137 (2).

Findings/Faits saillants :

1. Inspector reviewed a resident's health care records and noted that the licensee did not ensure that every administration of a drug to restrain a resident when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in section 36 of the Act was documented as per the requirements of O.Reg.79/10,s.137 (2). Specifically, documentation of discussions with the resident or, where the resident is incapable, the resident's substitute decision-maker, following the administration of the drug to explain the reasons for the use of the drug was not found. [s. 137. (2)]

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 when a resident is restrained by the administration of a drug under common law duty, the home will document as per the requirements of O, Reg.79/10, s. 137 (2), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 141. Licensee to stay in contact

Specifically failed to comply with the following:

s. 141. (1) Every licensee of a long-term care home shall maintain contact with a resident who is on a medical absence or psychiatric absence or with the resident's health care provider in order to determine when the resident will be returning to the home. O. Reg. 79/10, s. 141 (1).

Findings/Faits saillants :

1. A resident was transferred to a health care facility for assessment and treatment. For the period of the leave, Inspector could find no documentation that referenced the home had maintained contact with the resident's Power of Attorney/Substitute Decision-Maker (POA/SDM) or the health care provider while the resident was on the leave to determine when and/or if the resident was to return to the home.

In an interview with the Inspector, Social Worker did provide information that four days prior to the resident's automatic discharge from the home [because the number of days of the leave had been exceeded], the home did attempt to contact the family and the health care provider. This was the only attempt during the leave to make contact with the resident's SDM/POA and health care provider

The licensee did not maintain contact with the resident who was on a medical or psychiatric absence or with the health care provider, to determine the return date to the home. [s. 141. (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 the licensee maintains contact with the resident who is on a medical or psychiatric absence or with the health care provider to determine the return date to the home, 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. Inspector reviewed the home's policies and procedures in regards to restraints. Inspector notes that in Policy R-040: RESTRAINT DEFINITIONS, the home defines as one of the restraints "chemical restraints" The home links this restraint to emergency situations and common law duty: "duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others". On page 12 of this same policy, the home states that when common law duty is used : "# 5. the resident must be assessed every 15 minutes by physician, RN EC or registered staff and at any other time based on the resident's condition or circumstances"

Inspector reviewed a resident's health records where common law duty was invoked and the administration of a chemical restraint was used on several occasions. Inspector reviewed the resident's medication administration record and progress notes and observed that documentations were made every 1/2 hours [as opposed to the home's policy of every 15 minutes] and that there was a 2 hour gap where no documentation appeared. The home did not follow the procedure in it's policy: R-040

The licensee of the home did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:
(a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and
(b) complied with. [s. 8. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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. Inspector reviewed a resident's health care record and noted that the physician had ordered a medication to be given every four hours as necessary. Inspector noted one instance where the medication was given 36 minutes earlier than the physician's order of four hours between doses. The licensee did not ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 13th day of March, 2013

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

Monique Y. Berger (151)