



**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
Direction de l'amélioration de la
performance et de la conformité**

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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
Apr 28, 2014	2014_282543_0010	S-000129-14	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

TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): April 9-11th, 2014

The following logs were reviewed as part of this inspection: S-000129-14

**During the course of the inspection, the inspector(s) spoke with -the
Administrator**

- Director of Care**
- Registered nurses and Registered Practical nurses**
- Health Care Aides**
- Family members**
- Residents**

**During the course of the inspection, the inspector(s) -Observed the delivery of
care and services to residents**

- Conducted daily tours of all resident home areas**
- Reviewed staff education events**
- Reviewed resident health care records**
- Reviewed various home policies and procedures**

**The following Inspection Protocols were used during this inspection:
Responsive Behaviours**

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>



**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. According to a critical incident, resident #001 eloped from the Home and was found in the parking lot of a local store. Resident #001 was brought to hospital emergency department by ambulance for further assessment.

A roam alert bracelet audit from March 10th, 2014 revealed that resident #001's roam alert bracelet was functioning, however, resident #001 eloped from the home without any alarm sounding. In a conversation with the Administrator, he confirmed that resident #001 did not have a roam alert bracelet on when the resident exited the home. Resident #001's care plan outlined, that a roam alert bracelet was to be worn at all times to prevent elopement, and it is to be monitored for effectiveness.

Consequently, the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to resident #001 as specified in the plan, to be implemented voluntarily.



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Issued on this 28th day of April, 2014

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

Boucher
(#543)