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
Apr 29, 2014	2014_320576_0002	S-531-13, S-40-14, S-98-14	Critical Incident System

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

MARSHA RIVERS (576), TIFFANY BOUCHER (543)

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): April 9, 10, 11, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, registered nurses, registered practical nurses, health care aides, and residents.

During the course of the inspection, the inspector(s) conducted a walk through of the home, observed the provision of resident care, reviewed resident health care records, reviewed the responsive behaviour program, and reviewed applicable infection control policies.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. Inspector #576 reviewed the health care records for resident #003. The care plan and resident care flowsheets identify that the resident exhibits responsive behaviours including, but not limited to, refusing to bathe or shower. Inspector noted in the progress notes of April 3 and 7, 2014 that the resident refused a bath on these dates, however these responsive behaviours were not documented on the resident care flowsheets. Staff #101 told the Inspector that health care aide's (HCAs) are to document responsive behaviours on the resident care flowsheets. The Director of Care confirmed that the licensee's policy is for HCAs to document responsive behaviours on the resident care flowsheets. The licensee failed to ensure that their policy for documenting responsive behaviours is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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 responsive behaviours are documented according to the licensee's policy, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Inspector #576 reviewed the licensee's policy to promote zero tolerance of abuse and neglect of residents. The policy did not identify the training and retraining requirements for all staff including (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of power of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents deals with matters provided for in O.Reg. 79/10 section 96(e). [s. 20. (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 the licensee's policy to promote zero tolerance of abuse and neglect of residents deals with matters provided for in O.Reg. 79/10 section 96(e), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Inspector #576 reviewed the Critical Incident Report and health care records for resident #002 and resident #003. In an altercation between resident #002 and resident #003 that was overheard by staff, resident #003 sustained a physical injury. The Critical Incident Report initiated by the Director of Care, that identified the incident as resident to resident abuse, was not reported to the Director until 2 days after the date of the alleged abuse. The licensee failed to immediately report to the Director abuse of a resident that resulted in harm to a resident. [s. 24. (1) 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 the licensee immediately reports to the Director abuse of a resident by anyone that resulted in harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. Inspector #576 reviewed the Critical Incident Report and health care records for resident #002 and resident #003 which described an altercation between resident #002 and resident #003. The Inspector noted in the progress notes and in the Critical Incident Report that the Power of Attorney for Personal Care (substitute decision-maker) for resident #003 was informed of the altercation with resident #002, 2 days after the date of the altercation. The Director of Care confirmed that the substitute decision-maker for resident #003 was not notified of the altercation and physical injury until 2 days after the date of the alleged abuse and that no previous attempts had been made to contact the substitute decision-maker. The licensee failed to ensure that the resident's substitute decision-maker was notified immediately upon the licensee becoming aware of an alleged incident of abuse of the resident that resulted in a physical injury to the resident. [s. 97. (1) (a)]

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 resident's substitute decision-maker, if any, and any other person specified by the resident is notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or causes distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

Issued on this 29th day of April, 2014

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