



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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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

Personal Support Services
Resident Charges

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legende
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 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.]

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.

**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 :



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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)