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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 9, 2015	2015_331595_0012	011158-15	Resident Quality Inspection

Licensee/Titulaire de permis

CHAPLEAU HEALTH SERVICES
C/O CHAPLEAU GENERAL HOSPITAL 6 BROOMHEAD ROAD CHAPLEAU ON P0M 1K0

Long-Term Care Home/Foyer de soins de longue durée

THE BIGNUCOLO RESIDENCE
C/O Chapleau General Hospital P. O. Box 757, 6 Broomhead Road CHAPLEAU ON P0M 1K0

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

MARINA MOFFATT (595), MONIKA GRAY (594)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 29 - July 2, 6, 7, 2015

The following MOHLTC log was inspected concurrently: #002305-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), LTCH Team Lead, Nursing Admin Assistant, Registered Dietitian, Maintenance staff, Registered Practical Nurses, Family Members and Residents.

Throughout the inspection, inspectors conducted health care record reviews, observed resident care areas, and reviewed the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 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. The licensee failed to ensure that the care set out in resident #007's plan of care was provided to the resident as specified in the plan.

Inspector #595 reviewed a Critical Incident (CI) report which described that resident #007 was transferred by S #112 from their bed to their wheelchair. The report identified that the staff member transferred the resident independently using a pivot method. During the transfer, the resident's foot then became entangled with the other. The resident complained of pain a few hours later. An X-ray confirmed a fracture.

Inspector #595 spoke with S #106, #107, and #108 who confirmed that at the time of the incident, the staff had been using a pivot method to transfer the resident. Inspector asked S #106 what care plan on PointClickCare (PCC) was being used at the time of the incident. They stated that either the June or September 2014 version was used and instructed inspector to view both. Inspector reviewed the focus 'Transferring' in both care plans which revealed that the resident was to be transferred using a mechanical lift or transfer board (depending on the resident's strength/fatigue) with two staff assisting at all times.

Inspector spoke with the Director of Care (DOC) about the resident's care plan implemented at the time of the incident. The DOC retrieved a kardex and care plan with a print date of June 23, 2014 which identified that the resident required extensive assistance with transferring, required two person physical assist, and was to be lifted mechanically when the resident was weak or lethargic. The DOC confirmed that at the time of the transfer, only one staff was present and transferred the resident using a pivot method, and not a mechanical lift with two staff as identified in the care 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 resident #007's plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (3) The licensee shall assist in the establishment of a Family Council within 30 days of receiving a request from a person mentioned in subsection (2). 2007, c. 8, s. 59. (3).

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the home assisted in the establishment of a Family Council within 30 days of receiving a request from a family member of a resident or person of importance to a resident in the home.

Inspector #595 spoke with S #101 about the home's Family Council (FC), who stated that there was no FC at the home. They explained that they had sent out a survey back in February 2015 and only one person returned the survey expressing interest. There was also one other person who returned the survey, however they declined to participate shortly after. Inspector asked S #101 if they or the home had reached out to the person, and they stated that they had not, as the last question of the survey had not been completed.

Inspector spoke with the individual who submitted the survey. They indicated that they were still interested in participating in the FC. They also stated that the home had not contacted them after they submitted the survey back in March 2015. Inspector spoke with the Administrator who explained that they were not aware that someone had expressed interest in FC. [s. 59. (3)]

2. The licensee failed to ensure that the home convenes semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

Inspector #595 spoke with S #101 about the home's Family Council (FC). Inspector asked them if the home convened semi-annual meetings to advise residents' families of their right to establish a FC. They stated that they do not hold semi-annual meetings, rather they send out surveys once a year to family members. [s. 59. (7) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter; and body mass index and height upon admission and annually thereafter.

In an entrance interview with Inspectors #594 and #595, S #104 stated that residents' heights were taken on admission and annually thereafter, and weights are taken on the day of admission and monthly thereafter. All heights and weights are entered into PointClickCare (PCC).

During the census record review, Inspectors #594 and #595 reviewed the following current residents' health care records. Inspectors noted that the following residents had not had a height taken since their admission or on an annual basis. Resident admission dates were retrieved from the LTC Census as provided by the home, and weights were found on the Weights/Vitals tab in PCC:
- Resident #014: last height taken in 2013
- Resident #009: last height taken in 2012

- Resident #006: last height taken in 2011
- Resident #001: last height taken in 2011
- Resident #004: last height taken in 2013
- Resident #002: last height taken in 2013
- Resident #015: last height taken in 2013
- Resident #011: last height taken in 2012
- Resident #013: last height taken in 2012
- Resident #010: last height taken in 2012
- Resident #007: last height taken in 2011
- Resident #012: last height taken in 2013
- Resident #016: last height taken in 2013
- Resident #005: last height taken in 2011

Inspector #594 identified that when resident #022 was admitted they did not have a weight taken until thirteen days after admission.

The inspector reviewed the home’s policy 'Measuring and Monitoring Resident’s Weight and Height' (#ALH-02-13001) which stated that each resident’s weight is taken on admission, and no later than three days after admission, and each resident’s height is taken on admission and annually thereafter. [s. 68. (2) (e)]

2. It was noted by Inspector #595 that resident #023 had multiple heights documented in PCC prior to their admission, as a result of a previous admission. Inspector spoke with S #104 who confirmed the weights prior to admission to the LTCH. Inspector reviewed the documented heights and could not locate the resident’s height at the time of admission. [s. 68. (2) (e)]

Issued on this 9th day of July, 2015

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

Original report signed by the inspector.