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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2017	2017_435621_0023	019325-17	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

JULIE KUORIKOSKI (621), LAUREN TENHUNEN (196), NATASHA MILLETTE (686)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 11-17, 2017.

Additional intakes completed during this inspection included:

One intake related to follow up of a past due compliance order #001, for Long-Term Care Homes Act (LTCHA) s.19(1); and one intake related to follow up of a past due compliance order #001, for Ontario Regulation 79/10, s. 15 (1).

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Resident Assessment Instrument (RAI) Coordinator, the RPN Team Lead, the Registered Dietitian (RD), Dietary Aides, the Support Services Manager, the Activation Coordinator, the Nursing Administrative Assistant, the Patient Care Manager/Director of Care (DOC), the interim Chief Executive Officer (CEO), residents and families.

The Inspectors observed the delivery of care and services to residents, resident interactions, staff to resident interactions, conducted a tour of the resident home areas, reviewed resident health records, various home policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Sufficient Staffing
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2016_320612_0024	196

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents of the home were not neglected by the licensee or staff.

During this inspection, Inspector #621 was following up on an outstanding Compliance Order #001, issued during inspection #2016_273638_0022.

The home was ordered to:

"a) Ensure that all residents of the home are protected from neglect by staff of the home.
b) Identify every resident of the home who has altered skin integrity to ensure that it is identified in their plan of care and that the appropriate assessments, treatments, interventions and evaluations are implemented to address the altered skin integrity.
c) Retrain all staff on the home's policies and procedures related to the prevention of abuse and neglect, specifically focusing on the definition of neglect.
d) Retrain all direct care staff on the home's policies and procedures related to the skin and wound care program, focusing on the roles and responsibilities of staff related to identification, assessment, treatment, documentation and evaluation of the skin and wound care needs of all residents in the home.
e) Maintain a record of all required retraining, who completed the training, when the retraining was completed and what the retraining entailed."

1. Although the licensee had complied with sections "a and e" of the order, section "b", where the licensee was ordered to ensure that every resident in the home who had altered skin integrity had this information identified in their plan of care and had appropriate assessments, treatments, interventions and evaluations implemented, was not complied with.

During an interview on a day in September 2017, RPN Team Lead #105 reported to Inspector #621 that residents #008, #010 and #011 had altered skin integrity and/or risk of altered skin integrity at the time of the inspection. RPN Team Lead #105 indicated that it was identified from their auditing process that wound assessments were not being completed.

During a review of resident #008's plan of care by Inspector #621, it was indicated in their health care records that resident #008 had developed altered skin integrity which was identified by RPN#101 on a specific day in August 2017. On review of this resident's wound assessment report, it was noted that the first wound assessment had not been completed until a specified number of days after the altered skin integrity was first identified.

On the same day in September 2017, RPN Team Lead #105 reviewed resident #008's wound assessment records and confirmed to Inspector #621 that an initial wound assessment had not been completed on a specific day in August 2017, when altered skin integrity was discovered by RPN #101 and that an initial assessment had not be completed until a specified number of days later. Additionally, RPN Team Lead #105 confirmed that a wound assessment should have been completed on discovery of the altered skin integrity and every seven days thereafter, or more often if required, until the altered skin integrity had been resolved.

Inspector #621 reviewed the home's policy titled "Skin and Wound Care Maintenance – CLI-03-19003", last revised June 17, 2015, which indicated that a resident identified as having a wound/pressure ulcer(s), was to be assessed and documented by the nursing staff caring for the resident, with reassessment done and documented at a minimum weekly until the wound was resolved.

During an interview on another day in September 2017, the Patient Care Manager/DOC reported to Inspector #621 that it was their expectation that every resident with altered skin integrity was assessed by the home's RPN staff and that the wound assessment tool in Point Click Care (PCC), (which was the home's clinically appropriate wound assessment tool), was to be completed when altered skin integrity was first identified, as well as weekly until the altered skin integrity was resolved.

2. In respect to part "c" of the order, where the licensee was ordered to ensure all staff were retrained on the home's policies and procedures related to the prevention of abuse and neglect, with specified focus on the definition of neglect, was not complied with.

On a day in September 2017, Inspector #621 reviewed the home's documented education and training records relating to the required retraining of all staff on the home's prevention of abuse and neglect policy and procedures. On review of the "e-Learning Activity Report" provided as evidence of staff retraining, it was identified that the report was generated only for RN, RPN and PSW staff, and not for all staff employed to work in the home, as identified in the compliance order.

During an interview on another day in September 2017, the Patient Care Manager/DOC reported to Inspector #621 that they had not been clear about the order requiring all staff of the home to complete prevention of abuse and neglect retraining. On a subsequent day in September 2017, the Patient Care Manager/DOC provided Inspector #621 with the home's current training records relating to the retraining of all staff on the home's

prevention of abuse and neglect policy and procedures records. The Patient Care Manager/DOC confirmed to the Inspector that 70 per cent of the home's staff had not completed the required retraining as specified in the compliance order.

3. With respect to part "d" of the order, where the licensee was ordered to ensure all direct care staff were retrained on the home's policies and procedures related to the skin and wound care program, focusing on the roles and responsibilities of staff related to identification, assessment, treatment, documentation and evaluation of the skin and wound care needs of all residents in the home, was not complied with.

On a day in September 2017, Inspector #621 reviewed the home's documented education and corresponding "Education Session Sign-In Sheet" for the wound care education sessions provided to RN, and RPN staff. The training records identified that only 41 per cent of RNs and RPNs had completed the required training by the compliance order due date.

During an interview on another day in September 2017, the Patient Care Manager/DOC reported to Inspector #621 that RN #111 who had completed the staff retraining had kept the record of those staff trained, and that the line list of staff on the "Education Session Sign-In Sheet" was inaccurate, as there were staff listed on it who were on leave from work, or were no longer working for the home.

On a subsequent day in September 2017, the Patient Care Manager/DOC provided to Inspector #621 the home's training records relating to the required wound care training. The Patient Care Manager/DOC confirmed to the Inspector that 47 per cent of all direct care staff had not completed the required retraining as specified in the compliance order. [s. 19. (1)] (621)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

On a day in September 2017, Inspector #196 observed resident #001 using a mobility aide with a safety device in place. In addition, the resident's bed was observed with a number of safety devices in place.

Inspector #196 reviewed resident #001's health care record, including their care plan in place at the time of inspection, and identified that this resident's care plan did not reference the use of a mobility aid, and specific safety devices. Additionally, a review of the most recent physician's orders dated from the summer of 2017, did not include an order for the use of a mobility aid or a bed with specific safety devices. Furthermore, a consent signed by the Substitute Decision Maker (SDM) dated in early 2017, identified the use of a designated number of safety devices when the resident was utilizing their mobility aid or bed.

On a day in September 2017, Inspector #196 conducted interviews with RPNs #101 and #115, who reported that the resident used both their mobility device and bed with specific safety devices utilized at specific times. However, during a subsequent interview conducted with RPN Team Lead #105, they reported to Inspector #196 that resident #001 did not have a specified number of safety devices engaged when in bed as identified by RPN #101 and #115, but instead had another specific number of safety devices utilized when in bed, as identified in their most current care plan. [s. 6. (1) (c)] (196)

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On a day in September 2017, Inspector #196 observed the fabric chairs in the common dining room to be soiled with food debris and stains. There were 13 fabric covered chairs positioned at the dining tables, and it was noted that 10 of the 13 chairs had various levels of staining on the seat surfaces and back rests.

On another day in September 15, 2017, Inspector #196 conducted an interview and walk through of the common dining room with Support Services Manager #107, who reported to the Inspector that the stains found on the chairs were from resident incontinence and coffee spills and that since approximately July 1, 2017, stain removal was no longer being completed. However, Support Services Manager #107 indicated that the dietary staff members continued to disinfect the chairs.

On another day in September 2017, Inspector conducted interviews with Dietary Aides #103 and #104, who both reported to the Inspector that they wiped the dining room chair surfaces, including the fabric seating, leg and armrests with disinfectant after each meal. Dietary Aides #103 and #104 identified that they were aware that there were stains embedded into the fabric of the dining room chairs, but reported that they didn't have the proper equipment to remove the stains. [s.15. (2) (a)] (196)

2. On a day in September 2017, Inspector #621 observed a mobility aid belonging to resident #004 with specific parts of the mobility aid soiled and stained with food debris.

On another day in September 2017, Inspector #196 observed this resident’s mobility aid with the same soiling as noted by Inspector #621 on a previous day.

On a specific day in September 2017, Inspector #196 conducted an interview with RPN #115, who reported to the Inspector that the night shift RPNs were responsible for the surface cleaning of resident mobility aids. However, RPN #115 identified and that if a mobility aid was found to require deeper cleaning, that the RPNs would put the mobility aid in a certain location in the home for housekeeping staff to perform the task.

Subsequently, on the same day in September 2017, Housekeeping Aide #123 confirmed to Inspector #196 that if a resident's mobility aid needed deep cleaning, the RPN staff were to put the mobility aide in a certain location in the home and then the housekeeping staff would complete the task. Housekeeping Aide #123 also reported that in the past there was a schedule for cleaning of resident mobility aides, but at the time of inspection there the schedule was no longer being used by staff. [s. 15. (2) (a)] (196)

3. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On a day in September 2017, Inspector #196 observed several resident rooms with flooring which was stained and gouged in numerous areas. Specifically:
- gouges were found in the flooring around the bed located in a specific resident room;
- multiple gouges were found in the flooring located in another specific resident room;
- there was discoloured and stained flooring found in several areas throughout the home's common areas and resident corridors; and
- there was discoloured and stained flooring found in both the small and large tub rooms.

On another day in September 2017, Inspector #196 conducted an interview with Maintenance staff #124 regarding the flooring located in the long-term care unit. Maintenance staff #124 reported to the Inspector that the flooring was original to the home from 1995 and confirmed that the flooring was gouged in two specific resident rooms, and that there was stained and discoloured flooring in both the small and large tub rooms.

During an interview on a subsequent day in September 2017, with Support Services Manager #107, they reported to Inspector #196 that the areas of flooring that were gouged in resident rooms were from the bed wheels, and that the flooring was original from 1995. [s. 15. (2) (c)] (196)

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 home, furnishings and equipment are kept clean and sanitary; and to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee failed to ensure that every person hired by the licensee as a personal support worker, or to provide personal support services regardless of title, successfully completed a personal support worker program that met the requirements in subsection (2).

On a day in September 2017, Inspector #196 conducted an interview with PSW #119, who reported to the Inspector that they started working at the home in 2017. PSW #119 also reported to the Inspector and that they had taken nursing courses as part of a program other than a Personal Support Worker (PSW) program, and did not have a PSW certificate.

On another day in September 2017, Inspector #196 conducted an interview with Patient Care Manager/DOC #100 who reported to the Inspector that the home had hired on contract four PSWs who started in their roles in a specific month in 2017, and that the contract for these positions was for a specific period of time. In addition, Patient Care Manager/DOC #100 reported to the Inspector that the staff members who were hired were required to have a certificate as a PSW or the equivalent, and specifically:
- PSW #119 was hired from a program other than a PSW program and confirmed to be working as a PSW; and
- PSW #120 was no longer qualified to work as a PSW.

On a subsequent day in September 2017, Inspector #196 conducted an interview with the Interim Administrator #113 who confirmed to the Inspector that, the PSW positions commenced on a specific day in 2017. In addition, Interim Administrator #113 verified that PSW #102 had a certificate from a program other than a PSW program and they were waiting to find out from the Ministry of Health and Long-Term Care (MOHLTC) if that met the requirements to be employed to work as a PSW. Furthermore, Interim Administrator #113 confirmed that PSW #120 had not been qualified to work as a PSW when they were hired to work in the home in 2017. [s. 47. (1)] (196)

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 every person hired by the licensee as a personal support worker, or to provide personal support services regardless of title, has successfully completed a personal support worker program that meets the requirements in subsection (2), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents that had a weight change of five per cent body weight, or more, over one month, a change of seven and one-half per cent body weight, or more over three months, or a change of ten per cent of body weight, or more, over six months, were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

On a day in September 2017, during a review of weight loss indicated from resident #003's most recent Resident Assessment Instrument-Minimum Data Set (RAI-MDS), Inspector #621 identified a significant weight change. Additionally, the Inspector reviewed resident #003's health record and was unable to find documentation identifying that a referral to the Registered Dietitian (RD) had been made for the weight change.

During interviews on another day in September 2017, RPNs #101 and #115, reported to

Inspector #621 that residents were weighed by the RPN staff on their first bath day, or no later than the eighth day of each month. RPNs #101 and #115 identified that weights were recorded on the weight report found in each resident's electronic health record and that RPNs were responsible for checking weights for accuracy to the previous months recorded weight, and to re-weigh residents where weights triggered a significant weight change for potential weight errors. Additionally, RPNs #101 and #115 indicated that when there was a significant weight change, RPNs were to make a referral to the RD by either by electronic mail, phone or in person. RPN #115 reported that there was no method for the RPNs to verify whether a referral had been made to the RD to further assess resident #003's identified weight change.

Inspector #621 reviewed the home's policy titled "Registered Dietitian Referral – ALH-02-18001", last revised January 9, 2015, which indicated that referrals to the RD were to be made as soon as possible for situations necessitating a referral, which included significant weight changes, and RD referrals were made by completing a "Request for Service" electronically through Meditech or electronically via the internal electronic mail system. On review of the home's policy titled "Weight Change Management – ALH-02-23001", last revised August 8, 2017, a significant weight change was identified as 5 per cent or more over one month, 7.5 per cent or more over three months, 10 per cent or more over six months, or any other weight change that compromised the resident's health status.

In an interview on another day in September 2017, the RD verified to Inspector #621 that resident #003 had a significant weight change recorded in their electronic health record over a specific time frame in the summer of 2017. Additionally, the RD confirmed that they had not received a referral from the registered nursing staff to assess the weight change identified.

During an interview on another day in September 2017, Patient Care Manager/DOC #100 indicated that it was their expectation weight changes were being assessed using an interdisciplinary approach, and specifically, that RPNs were measuring resident weights monthly in accordance with the home's policy, entering them into the electronic health record, verifying weight accuracy through re-weigh when there was a significant weight change, and referring these weight changes to the RD by electronic mail, phone contact or in person on the same day when the weight was taken. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.] (621)

2. On a day in September 2017, during a review of weight loss indicated from resident

#004's most recent RAI-MDS assessment, Inspector #621 identified a significant weight change over a specific time period during the summer of 2017. Additionally, the Inspector reviewed resident #004's health record and was unable to find documentation identifying that a referral to the Registered Dietitian (RD) had been made for the specified weight change.

During interviews on another day in September 2017, RPNs #101 and #115, reported to Inspector #621 that when there was a significant weight change identified after taking the resident weight and entering it into the electronic weight report, RPNs were to make a referral to the RD by either by electronic mail, phone or in person. RPN #115 indicated that there was no method for the RPNs to verify whether a referral had been made to the RD to further assess resident #004's identified weight change.

In an interview on another day in September 2017, the RD verified to Inspector #621 that resident #004 had a significant weight change recorded in their electronic health record over a specific time period in the summer of 2017. Additionally, the RD confirmed that they had not received a referral from the registered nursing staff to assess the weight change. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.] (621)

3. On a day in September 2017, during a review of weight loss indicated from resident #005's most recent RAI-MDS assessment, Inspector #621 identified a significant weight change over a specific time period in the late summer of 2017. Additionally, the Inspector reviewed resident #005's health record and was unable to find documentation identifying that a referral to the Registered Dietitian (RD) had been made for the weight change.

During interviews on another day in September 2017, RPNs #101 and #115, reported to Inspector #621 that when there was a significant weight change identified after taking the resident weight and entering it into the electronic weight report, RPNs were to make a referral to the RD by either by electronic mail, phone or in person. RPN #115 identified that there was no method for the RPNs to verify whether a referral had been made to the RD to further assess resident #005's identified weight change.

In an interview on the same day in September 2017, the RD verified to Inspector #621 that resident #005 had a significant weight change recorded in their electronic health record over a specific time period in the late summer of 2017. Additionally, the RD confirmed that they had not received a referral from the registered nursing staff to assess the weight change. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.] (621)

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 residents that have a weight change of five per cent body weight, or more, over one month, a change of seven and one-half per cent body weight, or more over three months, or a change of ten per cent of body weight, or more, over six months, are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including the following: Access to these areas will be restricted to, persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

During medication observations made by Inspector #196 on a day in September 2017, RPN #101 reported to the Inspector that the Housekeeping Aides were aware of the pass code to the home's medication room door in order to enter unsupervised to complete housekeeping tasks. Located within the medication room, the Inspector observed a cupboard with government stock medication as well as three locked medication carts. RPN#101 also reported to Inspector #196 that the pass code to enter the medication room had not been changed since they had started working at the home for a specific period of time prior.

During an interview with Housekeeping Aides #123 and #125 on another day in September 2017, they reported to Inspector #196 that they were aware of the home's medication room pass code in order to gain access to complete housekeeping duties. Both Housekeeping Aides #123 and #125 confirmed that they were not registered staff members.

On the same day in September 2017, Inspector #196 conducted an interview with the Patient Care Manager/DOC, who reported to the Inspector that the pass code to the home's medication room had not been changed in a long time. In addition, they indicated that only registered staff and the pharmacy assistant should have had access to the medication room. [s. 130. 2.] (196)

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 steps are taken to ensure the security of the drug supply, including the following: Access to these areas is restricted to, persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy to minimize the restraining of residents, ensured that any restraining that was necessary was done in accordance with the Act and the regulations, and ensured that the policy was complied with.

On a day in September 2017, Inspector #196 observed resident #001 using their mobility aid with a safety device in place.

On another day in September 2017, RPNs #101 and #115 reported to Inspector #196 that resident #001 used a specified number of safety devices at a particular time of day, and a specific number of other safety devices in utilizing their mobility aid.

The licensee's policy titled "Restraint Policy - CLI-03-18001", with revision date of May 26, 2015, was reviewed by Inspector #196. The policy read "if a restraint is deemed necessary, a care plan is to be developed when the restraint is applied and all the necessary information included as outlined in the procedure below" and "if the restraint continues, the physician is to rewrite the order for the restraint quarterly (January, April, July and October)".

The health care records for resident #001 were reviewed by Inspector #196 for information regarding the use of safety devices. The current care plan at the time of inspection did not include the use of the specific number and type of safety devices as identified to the Inspector by registered staff the previous day. Additionally, the most recent "physician's order review" dated from a day in July 2017, did not include an order for a specific number and type of safety devices as identified to the Inspector by the registered staff.

In an interview conducted with Patient Care Manager/DOC #100 on a day in September 2017, they reported to Inspector #196 that the use of a safety device was to be documented in the resident's care plan, and include information identifying the type of device being used, as well as the type of monitoring and repositioning required. [s. 29. (1) (b)] (196)

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Residents' Council advised the licensee of concerns or recommendations, the licensee within 10 days of receiving the advice, responded to the Residents' Council in writing.

During an interview on a day in September 2017, resident #009, (who was an active member of Residents' Council), reported to Inspector #621 that the home's management did not always respond to concerns raised at Resident's Council, and that responses were not received by Resident' s Council in writing within 10 days of specific concerns being raised at Council.

On the same day in September 2017, Inspector #621 reviewed copies of Residents' Council meeting minutes from the previous year, and noted the following recommendations and concerns raised by Resident Council members:
- During the January 9, 2017, Residents' Council meeting, residents identified that they disliked the Swedish meatballs and requested they be removed from the menu; that fried eggs were routinely cold when served, that residents desired more grilled cheese sandwiches be made to ensure there was enough when served, and that several residents found the dining room temperature to be too cold.
- During the February 13, 2017, Residents' Council meeting resident again expressed their desire to have Swedish meatballs removed from the menu, that residents desired there to be soup served with grilled cheese sandwiches, that food being served was not hot enough, and that the coffee was cold.

The Inspector reviewed the Residents' Council meeting minutes from February 13 and March 6, 2017, and identified that there was no documented response from the licensee to any of the identified concerns brought forward from the respective previous month's meetings.

During an interview on a day in September 2017, Activation Coordinator #114, who

served as the Assistant to Residents' Council, reported to Inspector #621 that management representation from the licensee, which included the DOC/Administrator of the home were notified by email of resident recommendations and/or concerns brought forward at Residents' Council meetings, and that for the issues raised by residents from the January 9, and February 13, 2017 meetings, there had been no written response provided within 10 days.

Inspector #621 reviewed copies of email correspondence from Activation Coordinator #114 to the DOC/Administrator #100, and Support Services Manager #107 dated from January 10 and February 16, 2017, which identified issues from the January 9 and February 13, 2017, Residents' Council meetings, and requested a return response within 10 days.

During interviews on two days in September 2017, Patient Care Manager/DOC #100 confirmed to Inspector #621 that both the Support Services Manager #107 and themselves were aware of the issues raised from Residents' Council meetings, including those concerns raised at the January 9 and February 13, 2016, meetings, and confirmed that a written response had not been provided within 10 days as per legislative requirements. [s. 57. (2)] (621)

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that they consulted regularly with Residents' Council, in any case at least every three months.

During an interview on a day in September 2017, resident #009, (who was an active member of Residents' Council), reported to Inspector #621 that the home's management staff had not consulted with Residents' Council, at least every three months over the previous year.

On the same day in September 2017, Inspector #621 reviewed copies of the Residents' Council meeting minutes from January to August 2017, and identified that with exception of the Assistant to Residents' Council, there was no documented representation of the licensee at four meetings convened between March and August 2017.

During an interview on the same day in September 2017, Activation Coordinator #114, who served as the Assistant to Residents' Council, reported to Inspector #621 that management representation from the licensee, which included the Patient Care Manager/DOC of the home, had not consulted with Residents' Council at least every three months for a six month period in 2017.

During an interview on a subsequent day in September 2017, the Patient Care Manager/DOC of the home reported to Inspector #621 that they or a representative of the licensee had not consulted with Residents' Council, in any case, at least every three months, as per legislative requirements. [s. 67.] (621)

Issued on this 6th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE KUORIKOSKI (621), LAUREN TENHUNEN (196), NATASHA MILLETTE (686)
Inspection No. / No de l'inspection :	2017_435621_0023
Log No. / No de registre :	019325-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 26, 2017
Licensee / Titulaire de permis :	CHAPLEAU HEALTH SERVICES C/O CHAPLEAU GENERAL HOSPITAL, 6 BROOMHEAD ROAD, CHAPLEAU, ON, P0M-1K0
LTC Home / Foyer de SLD :	THE BIGNUCOLO RESIDENCE C/O Chapleau General Hospital, P. O. Box 757, 6 Broomhead Road, CHAPLEAU, ON, P0M-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jamie Fiaschetti

To CHAPLEAU HEALTH SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_273638_0022, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall:

a) Ensure that all residents of the home are protected from neglect of staff.

b) Ensure resident #008 and every resident of the home who has altered skin integrity has the appropriate assessments completed to address the altered skin integrity.

c) Ensure all staff are trained on the home's prevention of abuse and neglect policies and procedures.

d) Ensure all direct care staff are trained on the home's policies and procedures related to the skin and wound care program.

Grounds / Motifs :

1. The licensee has failed to ensure that residents of the home were not neglected by the licensee or staff.

During this inspection, Inspector #621 was following up on an outstanding Compliance Order #001, issued during inspection #2016_273638_0022.

The home was ordered to:

"a) Ensure that all residents of the home are protected from neglect by staff of the home.

b) Identify every resident of the home who has altered skin integrity to ensure that it is identified in their plan of care and that the appropriate assessments, treatments, interventions and evaluations are implemented to address the altered skin integrity.
c) Retrain all staff on the home's policies and procedures related to the prevention of abuse and neglect, specifically focusing on the definition of neglect.
d) Retrain all direct care staff on the home's policies and procedures related to the skin and wound care program, focusing on the roles and responsibilities of staff related to identification, assessment, treatment, documentation and evaluation of the skin and wound care needs of all residents in the home.
e) Maintain a record of all required retraining, who completed the training, when the retraining was completed and what the retraining entailed."

1. Although the licensee had complied with sections "a and e" of the order, section "b", where the licensee was ordered to ensure that every resident in the home who had altered skin integrity had this information identified in their plan of care and had appropriate assessments, treatments, interventions and evaluations implemented, was not complied with.

During an interview on a day in September 2017, RPN Team Lead #105 reported to Inspector #621 that residents #008, #010 and #011 had altered skin integrity and/or risk of altered skin integrity at the time of the inspection. RPN Team Lead #105 indicated that it was identified from their auditing process that wound assessments were not being completed.

During a review of resident #008's plan of care by Inspector #621, it was indicated in their health care records that resident #008 had developed altered skin integrity which was identified by RPN#101 on a specific day in August 2017. On review of this resident's wound assessment report, it was noted that the first wound assessment had not been completed until a specific number of days after the altered skin integrity was first identified.

On the same day in September 2017, RPN Team Lead #105 reviewed resident #008's wound assessment records and confirmed to Inspector #621 that an initial wound assessment had not been completed on a specific day in August 2017, when altered skin integrity was discovered by RPN #101 and that an initial assessment had not be completed until a specific number of days later. Additionally, RPN Team Lead #105 confirmed that a wound assessment should

have been completed on discovery of the altered skin integrity and every seven days thereafter, or more often if required, until the altered skin integrity had been resolved.

Inspector #621 reviewed the home's policy titled "Skin and Wound Care Maintenance – CLI-03-19003", last revised June 17, 2015, which indicated that a resident identified as having a wound/pressure ulcer(s), was to be assessed and documented by the nursing care staff for the resident, with reassessment done and documented a minimum weekly until the wound was resolved.

During an interview on another day in September 2017, the Patient Care Manager/DOC reported to Inspector #621 that it was their expectation that every resident with altered skin integrity was assessed by the home's RPN staff and that the wound assessment tool in Point Click Care (PCC), (which was the home's clinically appropriate wound assessment tool), was to be completed when altered skin integrity was first identified, as well as weekly until the altered skin integrity was resolved.

2. In respect to part "c" of the order, where the licensee was ordered to ensure all staff were retrained on the home's policies and procedures related to the prevention of abuse and neglect, with specified focus on the definition of neglect, was not complied with.

On a day in September 2017, Inspector #621 reviewed the home's documented education and training records relating to the required retraining of all staff on the home's prevention of abuse and neglect policy and procedures. On review of the "e-Learning Activity Report" provided as evidence of staff retraining, it was identified that the report was generated only for RN, RPN and PSW staff, and not for all staff employed to work in the home, as identified in the compliance order.

During an interview on another day in September 2017, the Patient Care Manager/DOC reported to Inspector #621 that they had not been clear about the order requiring all staff of the home to complete prevention of abuse and neglect retraining. On a subsequent day in September 2017, the Patient Care Manager/DOC provided Inspector #621 with the home's current training records relating to the retraining of all staff on the home's prevention of abuse and neglect policy and procedures records. The Patient Care Manager/DOC confirmed to the Inspector that 70 per cent of the home's staff had not

completed the required retraining as specified in the compliance order.

3. With respect to part "d" of the order, where the licensee was ordered to ensure all direct care staff were retrained on the home's policies and procedures related to the skin and wound care program, focusing on the roles and responsibilities of staff related to identification, assessment, treatment, documentation and evaluation of the skin and wound care needs of all residents in the home, was not complied with.

On a day in September 2017, Inspector #621 reviewed the home's documented education and corresponding "Education Session Sign-In Sheet" for the wound care education sessions provided to RN, and RPN staff. The training records identified that 59 per cent of RNs and RPNs had not completed the required training by the compliance order due date.

During an interview on another day in September 2017, the Patient Care Manager/DOC reported to Inspector #621 that RN #111 who had completed the staff retraining had kept the record of those staff trained, and that the line list of staff on the "Education Session Sign-In Sheet" was inaccurate, as there were staff listed on it who were on leave from work, or were no longer working for the home.

On a subsequent day in September 2017, the Patient Care Manager/DOC provided to Inspector #621 the home's training records relating to the required wound care training. The Patient Care Manager/DOC confirmed to the Inspector that 47 per cent of all direct care staff, including RNs, RPNs and PSW staff had not completed the required retraining as specified in the compliance order.

The decision to re-issue this compliance order was based on the scope of this issue which was a) a pattern of direct care staff not being retrained on the home's skin and wound program, b) a pattern of all staff not being retrained on the home's policies and procedures related to prevention of abuse and neglect, and c) an isolated incident where resident #008 did not have the appropriate wound assessment completed when altered skin integrity had been first identified. The severity of the issues indicated a potential for actual harm; and the compliance history identified that in spite of a previous compliance order issued in report #2016_27628_0022, there was continued non-compliance with this area of the legislation. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 26th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Julie Kuorikoski

Service Area Office / Bureau régional de services : Sudbury Service Area Office