Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 17, 2021	2021_895609_0005	017391-21, 017392-21	Follow up

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, 6 Broomhead Road P.O. Box 757 Chapleau ON P0M 1K0

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

KAREN HILL (704609)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 7-9, 2021.

The following intakes were inspected upon during this Follow up inspection:

One intake - Follow up to order #001 from inspection 2021_638542_0020 related to restraining of a resident by a physical device.

One intake - Follow up to order #002 from inspection 2021_638542_0020 related to restraining of a resident by a physical device.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Infection Prevention and Control (IPAC) Lead, Reception, Activation Coordinator, and Housekeeping staff.

The Inspector conducted a daily tour of resident care areas, observed residents and resident care, observed staff to resident interactions, observed IPAC practices, reviewed relevant resident records, staffing schedules and staff training records, as well as the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Minimizing of Restraining
Safe and Secure Home

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

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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. 110. (1)	CO #001	2021_638542_0020	704609
O.Reg 79/10 s. 110. (2)	CO #002	2021_638542_0020	704609

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	Légende 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for the residents related to COVID-19 active screening for all persons entering the home.

COVID-19 Directive #3 identified that homes must ensure that all individuals were

actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the home.

The Ministry of Health COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes identified, at a minimum, the questions that needed to be asked when actively screening individuals who enter the home.

A memo was sent to all Long-Term Care Home Licensees on November 29, 2021, which indicated an additional requirement for homes to include active screening about travel to specific countries identified by the federal government as subject to new travel restrictions related to the Omicron variant of concern.

On all three days of the inspection, the Inspector was screened by the receptionist using the home's standardized screening tool for visitors. It did not include all the questions that were required to be asked when actively screening individuals who entered the home nor the additional question related to travel to countries subject to the new travel restrictions.

On the third day, the Inspector observed a visitor being screened. The receptionist did not ask the minimum required screening questions as listed on the Ministry of Health COVID-19 Screening Tool nor about travel to countries subject to travel restrictions.

The home's standardized screening tool for visitors and the self-screening, electronic tool used by staff at the time of the inspection, did not include the minimum required screening questions, nor the additional question about travel to countries subject to new travel restrictions.

Two staff members verified that the questions on the screening tools were the questions that were used for screening. They confirmed that the results of the self-screening by staff members were not verified or reviewed by any one prior to the staff entering the home. They indicated that these would be the same practices with their designated visitors, starting December 15, 2021.

Additionally, in separate interviews, two staff members and the IPAC Lead indicated they were not aware of the recent directive for active screening about travel to countries subject to the new travel restrictions related to the Omicron variant of concern. The IPAC Lead verified they had received a memo from the Public Health Unit related to COVID-19 variant of concern, however, had not read it.

Not ensuring, that an active screening process was always in place and that at a minimum, the required screening questions were asked when actively screening individuals who entered the home, put residents in the home at potential risk of exposure to COVID-19.

Sources: Observations, COVID-19 Directive #3, dated July 16, 2021, Ministry of Health COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes, dated August 27, 2021, Directive #3, COVID-19 Guidance Document for LTCHs, and Rapid Testing Merged FAQs., dated September 28, 2021, MLTC, COVID-19 guidance document for long-term care homes in Ontario, dated October 12, 2021, Ministry of Long-Term Care, Associate Deputy Minister's Memo to all Long-Term Care Home Licensees : New COVID-19 Variant of Concern, dated November 29, 2021, the home's COVID-19 screening tools, and interviews with the IPAC Lead and other staff. [s. 5.]

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 is a safe and secure environment for the residents, specifically that all persons entering the home are screened for COVID-19 as per COVID-19 Directive #3, to be implemented voluntarily.

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

A resident's plan of care included the following:

- The care plan read that two physical devices and a monitoring device were to be applied daily while in their chair.

- The orders in the electronic record named a different physical device and the monitoring device were to be used.

- The Physician's orders indicated that two other physical devices and the monitoring device were to be applied. The orders also indicated that a restraint or PASD could be applied when needed.

- The consent for use of a physical device documented that another type of physical device and the monitoring device were to be used.

The resident was observed on three occasions in their chair, with one of the listed physical devices being utilized.

In separate interviews with two staff members, they confirmed that the plan of care for

the resident did not set out clear directions to staff and others who provided direct care to the resident related to the physical device that was to be used.

Not setting out clear directions in the plan of care for the resident, may have resulted in the incorrect devices being applied.

Sources: Observations of the resident, the resident's care plan, electronic orders, physician orders, consent record, and interviews with staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented, specifically related to the resident's condition being reassessed, and the effectiveness of the physical device in use being evaluated every eight hours.

The home’s policy on restraint use, indicated that staff were to reassess the effectiveness and the need of the physical device every eight hours and to document this in the electronic chart.

A review of the electronic documentation records for the resident from an identified time frame, indicated that on four occasions, there was no documentation related to the reassessment of the resident's condition, nor of the evaluation of the effectiveness of the physical device in use.

During separate interviews with three staff members, they all indicated that they had conducted the required reassessments related to resident's condition and the effectiveness of the physical device in use; however, they had forgotten to document their assessments, and they should have.

The home’s failure to ensure that there was documentation of the condition of the resident and the effectiveness of the physical device in use, at least every eight hours, may have impacted the resident’s safety and the need for ongoing use of the physical device.

Sources: Resident's electronic health record, the home’s policy on restraints, and interviews with staff members. [s. 6. (9) 1.]

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 the 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. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licensee that the licensee shall comply with every order made under this Act.

This inspection was completed as a Follow up to order #001 from inspection 2021_638542_0020 related to the restraining of a resident by a physical device.

On October 28, 2021, the CO #001 from inspection 2021_638542_0020 was issued under O. Reg. 79/10, s. 110 (1) of the Long-Term Care Homes Act, 2007.

CO #001 stated: the licensee must comply with O. Reg. 79/10, s. 110 (1).

Specifically, the licensee shall prepare, submit, and implement a plan to ensure that all staff who apply physical restraints to the residents, follow the manufacturer’s instructions for the device, and that the plan must include but not be limited to:

- a detailed description of all physical restraints used on residents in the LTC home, ensuring consistent terminology is used to prevent confusion;

- a plan on how the home will ensure that all staff who apply restraints to the residents are trained on the appropriate application of such devices, including who will be responsible for providing the training, name of staff trained, date of the training and the content of the training;

- develop an auditing process to evaluate the proper use of the physical restraints in home, and maintain a record of the audit for one month, and provide to the Inspector when required and;

- revise the home's current policy and procedure on restraints to meet the legislative requirements.

The compliance date was November 17, 2021.

The licensee failed to complete bullets one to four as ordered.

A review of the resident's plan of care revealed inconsistent terminology was being used when referencing their restraint.

During separate interviews with registered staff, they verified the terminology was confusing related to the restraint in use for the resident, and that it was not consistent and should be.

A review of a recently updated training module on restraints in the home for staff of the Bignucalo Residence, revealed it did not include a specific restraint currently being used in the home, as an approved restraint for use in the home.

During three separate observations, the Inspector noted that the restraint being utilized on the resident, was not on the list of restraints that were approved for use in the home.

Further to this, a review of the home’s training records indicated that all staff who applied restraints in the home had not received the required training on the appropriate application of restraints.

An interview with a staff member indicated that the training module was updated to

include all restraints approved for use in the home, and that all staff who applied restraints in the home were assigned the training which was to be completed by the dates identified.

A review of the auditing process developed by the home revealed that an audit to evaluate the proper use of physical restraints had not been completed.

The Administrator acknowledged that while they had developed the audit tool by the compliance date, they had not yet completed the audit.

The home's recently revised restraint policy indicated it had been updated to reflect the current legislation. A review of the revised policy revealed the required process for evaluating the use of restraints in the home to ensure compliance with the Act and Regulations was not included.

The home's Administrator verified that the update had been done to reflect current legislation and should be consistent with what was required.

The licensee has failed to comply with CO #001 from inspection 2021_638542_0020 that was made under the Act.

Sources: Observations of the resident, review of the home's policy, "Restraint Policy", CLI-03-18001, revised November 13, 2021, training module, "Restraints in LTC for the staff of the Bignucalo Residence", updated November 14, 2021, staff training records related to restraint use, Physical Restraint Audit tool, and interviews with the Director of Care, the Administrator, and other staff. [s. 101. (3)]

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 the licensee is compliant with the ACT and every order made under the ACT, to be implemented voluntarily.

Issued on this 21st day of December, 2021

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

Original report signed by the inspector.