Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: February 14, 2023	
Inspection Number: 2023-1349-0002	
Inspection Type: Follow up Critical Incident System	
Licensee: Chapleau Health Services	
Long Term Care Home and City: The Bignucolo Residence, Chapleau	
Lead Inspector Karen Hill (704609)	**Inspector Digital Signature** Karen L Hill Digitally signed by Karen L Hill Date: 2023.02.16 14:40:05 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
February 6-8, 2023

The following intake(s) were inspected:

- Intake: #00008425-2864-000015-22: Fall of resident resulting in injury.
- Intake: #00015031-Follow-up to CO #001 - FLTCA, 2021 - s. 6 (2), CDD January 3, 2023, from Inspection 2022-1349-0001, related to Plan of Care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2022-1349-0001 related to FLTCA, 2021, s. 6 (2) inspected by Karen Hill (704609)

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident was assessed for fall risk as specified in their plan of care.

Rationale and Summary
A resident was identified to be at high risk for falls. The resident had several falls; one of which resulted in a significant injury.

The resident's plan of care indicated that the resident, at specified times, was to be assessed for fall risk.

A review of the resident's health record indicated that on several occasions, the fall risk assessments were not completed at the specified times.

A registered staff member confirmed that the fall risk assessments were not completed when required and as outlined in the resident's plan of care.

Failure to complete fall risk assessments as set out in resident's plan of care, may have increased the risk for actual harm to the resident and put the resident at further risk for harm.

Sources: A resident's health record; the home's fall incident reports; the home's policy titled, "Fall Prevention Program–Long Term Care", revised May 2021; and interviews with registered staff and the Director of Care.

[704609]