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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 16, 2014	2014_282543_0014	S-000191-14	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

TIFFANY BOUCHER (543), LINDSAY DYRDA (575)

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): May 5th-16th, 2014

During the course of the inspection, the inspector(s) spoke with the CEO, Director of Clinical Services (DOC), Team Lead, Administrative Assistant, Manager of Support Services, Activation staff, Dietary Staff, Registered Nurses and Registered Practical Nurses, Residents and Family members.

During the course of the inspection, the inspector(s)
- Directly observed the delivery of care and services to residents
- Conducted resident and family interviews
- Walked throughout all resident home areas
- Directly observed dining and meal service
- Observed fluid and nourishment passes
- Reviewed resident health care records
- Reviewed staffing patterns for RNs, RPNs
- Reviewed various home policies and procedures

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. (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. On May 8, 2014 inspector #575 reviewed the most recent care plan for resident #8512. Interventions for resident #8512 included treatment for stage 2 and 3 ulcers. Inspector #575 reviewed progress notes that indicated that one ulcer had healed and three weeks later the second ulcer was healed. Inspector #575 confirmed with two staff members that the resident's current care plan did not include up to date treatment interventions.
Therefore, the licensee did not ensure the plan of care set out clear directions to staff and others who provide direct care to resident #8512. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Inspector #543 reviewed the home's Policy-Falls Prevention Program-Long Term Care- LTC-03-06001. The policy states that nursing staff will be oriented to the Falls Prevention Program and will attend annual training. The home was not able to provide any attendance records for nursing staff that attended the Falls Prevention annual training. Inspector spoke with DOC, who confirmed that education attendance records for nursing staff are unavailable for the year 2013.
Therefore, the licensee did not ensure that their policy instituted or otherwise put in place is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. On May 15, 2014 inspector #575 reviewed the medication administration records (MAR) for resident #8523 for the months of April and May, 2014. Inspector noted that the MAR was missing signatures for the following dates: April 11, 12, 30, and May 6, 12. Inspector reviewed the MAR for resident #8528 for the months of April and May, 2014. Inspector noted that the MAR was missing signatures for the following dates: April 2, 10, 15, 29.

Inspector #575 confirmed with LTC Team Lead that staff are to sign each day or indicate why the medication was not given using the legend on the MAR. Staff confirmed that if the medication was not given it should be indicated in the progress notes. Inspector #575 reviewed the progress notes for the above dates. There were no progress notes to indicate why the medication was not provided or signed as being administered.
Inspector #575 reviewed the Medication Administration Policy dated October 2012 which indicated that if a medication is not given for any reason it is to be recorded on the MAR.
Therefore, the licensee did not ensure that their policy instituted or otherwise put in place, is complied with. [s. 8. (1)]

3. Inspector #543, reviewed resident #8519's health care records, the LTC Surveillance Record identified that resident was administered Step 1 TB, on December 11, 2010. Result was read on December 13th, 2010 with a negative result. Step 2 TB was administered on December 18th, 2010. Result was read on December 19th, 2010. The reading was done 24 hours post administration which does not comply with the home's policy- Tuberculosis (TB) Test Mantoux- LTC-02-20001. Policy states, TB is administered and within 48-72 hours the nurse reads the test to determine if the test is negative or positive.
Consequently, the licensee did not ensure that their policy instituted or otherwise put in place, is complied with. [s. 8. (1)]

4. On May 15, 2014 inspectors #575 and #543 completed a food temperature audit for the months of March and April 2014. The inspectors reviewed the home's documented food temperature sheets and noted that 51% of the time, hot food was served under 60 degrees Celsius.

Inspector #575 reviewed the Temperature Control policy (FOS-07-20001) and noted that food must be held at temperatures where bacterial growth is controlled at a temperature greater than 60 degrees Celsius. The home's Sanitation and Safety Standards and Criteria manual states that the hot food temperature is to be maintained at a temperature above 60 degrees Celsius until service. The temperature control sheets identify that if a food item does not meet the recommended 60 degrees Celsius that the item must be reheated to the recommended temperature before serving.

On May 14, 2014 inspector #575 interviewed a staff member regarding the food

temperature policy. The staff member stated that if a temperature was less than 60 degrees Celcius, the policy states staff are to take food back to the kitchen, if time permits to be re-heated, otherwise staff are to use the microwave. The staff member indicated that if the food was re-heated, the new temperature would be recorded on the temperature sheet under the first temperature recording.

On May 15, 2014 the DOC and RD confirmed with inspector #575 that hot food should be served at a temperature of at least 60 degrees Celsius as directed on the food temperature sheets.

Therefore, the licensee did not ensure that the home's policy regarding food temperatures is complied with. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. Inspector #543 spoke with DOC and Team Lead, who confirmed that the home informs residents and their families upon admission that dental care is available, at an out of pocket cost to the resident/family. DOC and Team Lead also confirmed that the home is not offering residents annual dental assessments and other preventative dental services. Additionally, the DOC and Team Lead stated that in the future the home will incorporate offering dental assessments/services in their Annual Resident Care Conference.
Consequently, the licensee did not ensure that the resident is offered an annual dental assessment and other preventative dental services. [s. 34. (1) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. Inspector #575 requested skin and wound care staff training records. Copies of the 2012 wound care training records were provided. On May 15, 2014, the DOC confirmed that the home does not have training records for 2013. The wound care nurse told the DOC that she did not know she was required to document attendance. An audit of the attendance records indicated that 10/19 RPNs or 52.6% of direct care staff attended training in 2012. The licensee did not ensure that direct care staff are provided annual training in skin and wound care. [s. 221. (1) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Inspector #575 observed dining service on May 5, 13, and 14, 2014. On four occasions, food services staff were observed applying gloves then proceeding to

serve residents food, then touching cupboards and opening the fridge with the same gloves, then continuing to serve and touch plated food with the same gloves. No handwashing or change in gloves was observed between tasks. On May 15, 2014 inspectors #575 and #543 interviewed the Infection Control staff and Support Services Manager who confirmed that food services staff are to change their gloves and wash their hands between tasks. They both confirmed it was not acceptable for staff to apply gloves, handle food, touch cupboards, and continue to handle food with the same gloves.

Consequently, staff in the home did not participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. Inspector #543 spoke with Infection Control Team Lead, and Manager of Support Services to bring forward observations during the inspection. On several occasions, Inspectors #543 and #575 observed dietary staff serving residents their meals with gloved hands, without washing hands or changing gloves after performing other tasks. Inspectors also, observed the staff, placing food on plates with gloves that were not changed after touching numerous areas in the kitchen, as well as wiping gloves on dish rags and adjusting clothing.

The home's Policy- Hand Hygiene- INC-00-08001, identified that staff are to perform hand hygiene before and after contact with patients, their body substances or items in their environment. The policy also identified that hand hygiene will be performed between different procedures on the same resident, and before and after personal functions.
The Infection Control Team Lead and the Manager of Support Services also confirmed, that staff are to perform hand hygiene including changing gloves between every task they perform.

Consequently, staff in the home did not participate in the implementation of the infection prevention and control program. [s. 229. (4)]

3. Inspector #543, reviewed Meditech documentation for resident #8516, who was administered Step 1 TB, on May 28th, 2009. Result was read on May 30th, 2009 with a negative result. Step 2 TB was administered to same resident, on June 4th, 2009. The Home was not able to provide a result for that test to the Inspector. As well, these findings differ from what was identified in this resident's record in Point Click Care (PCC). PCC identified that resident #8516 was given Step 1 TB on January 20, 2009

and a Step 2 was administered on June 6, 2009.
Inspector #543, reviewed resident #8533's health record, the LTC Tuberculosis Surveillance Record identified that resident was administered Step 1 TB, on July 15th, 2013. Result was read on July 17th, 2013 with a negative result. There is no documentation that identifies that a Step 2 TB test was administered in the residents' health record in Point Click Care.
The above findings, are not in compliance with the home's Policy- Tuberculosis (TB) Test (Mantoux Test)- LTC-02-20001. The policy identifies that results of TB screening are to be documented and available to the licensee. [s. 229. (10) 1.]

Issued on this 17th day of June, 2014

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