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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 7, 2016	2016_320612_0022	001647-16	Resident Quality Inspection

Licensee/Titulaire de permis

The West Nipissing General Hospital
725 Coursol STURGEON FALLS ON P2B 2Y6

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

THE WEST NIPISSING GENERAL HOSPITAL
725 COURSOL STURGEON FALLS ON P2B 2Y6

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

SARAH CHARETTE (612), SYLVIE BYRNES (627)

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): August 29, to September 1, 2016

The Inspectors also conducted a Follow Up, related to no clear direction in the plan of care and a Critical Incident related to a resident's fall.

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Officer (CNO), President and CEO, Long-Term Care (LTC) Unit Manager, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Registered Dietitian, Dietary Aide, Recreationalist, Infection Prevention and Control Coordinator, residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to residents interactions, reviewed residents' health care records, staffing schedules, and resident council meeting minutes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 VPC(s)**
- **0 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2016_269627_0006	627

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. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the public inspection reports from the past two years were posted in the home, in a conspicuous and easily accessible location.

During the initial tour of the home, Inspector #627 noted that only Follow Up Inspection #2016_269627_0006, was posted on the cork board in the main hallway of the nursing home.

The Inspector reviewed the home's compliance history for the last two years and noted that the following inspections were conducted and not posted:
- Follow Up Inspection #2016_269627_0006, from February 8, 2016,
- Follow Up Inspection #2015_326012_0018, from October 6, 2015,
- Complaint Inspection #2015_320612_0019, from October 6, 2015,
- Resident Quality Inspection #2015_331595_0006 on April 13, 2015.

During an interview with the Inspector, the Chief Nursing Officer (CNO) stated that they posted the Inspection reports in the main hallway of the nursing home, on the cork board. Upon review of the cork board with the Inspector, the CNO confirmed that only the last Follow Up Inspection #2016_269627_0006 was displayed. [s. 79. (3) (k)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in the development and carrying out of the satisfaction survey, and in acting on its results.

During an interview, a member of the Residents' Council stated that the Council was not asked to review the survey questions in 2015, and that they were not provided with the results of the surveys.

During an interview with Inspector #627, staff member #112 stated that the Residents' Council was not asked for advice in developing and carrying out the satisfaction survey, nor were they asked for advice on acting on its results.

During an interview with the Inspector, staff member #101 confirmed that the Residents' Council was not asked for advice in developing and carrying out the satisfaction survey, nor were they asked for advice on acting on its results. [s. 85. (3)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director, under subsection (1), (3) or (3.1), set out the following with respect to the incident: v. the outcome or current status of the individual or individuals who were involved in the incident.

Inspector #612 reviewed a Critical Incident (CI) report submitted by the home to the Director in September 2014. The CI report described that resident #006 had fallen, was assessed by the RPN, the Physician was notified and the resident was sent out for further assessment.

The Director had requested that the CI be updated to include information regarding the health status of the resident upon their return to the home. The Inspector was unable to locate this information in the CI report.

The Inspector reviewed resident #006's health care records which stated that the resident had sustained an injury which resulted in a change in their health status.

The Inspector interviewed staff member #101 who stated that they were unaware that the outcome was not included in the CI report and they were unsure why it had not been updated when the Director had requested. [s. 107. (4) 3. v.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents were communicated to the Residents' Council.

During an interview with Inspector #627, a member of the Residents' Council stated that the Residents' Council was not made aware of quality improvements and utilization system to the accommodations, care, services, programs and goods provided to the residents.

During an interview with the Inspector, staff member #112 stated that issues with laundry, food and activities was the focus of the Residents; Council. They further stated that they were not aware of the home making the Residents' Council aware of the quality improvements and utilization system to accommodations, care, services, programs and goods provided to the resident.

During an interview with the Inspector, staff member #101 stated that the improvement and utilization systems program was part of the hospital, although it included the Nursing Home. They confirmed that the quality improvements and utilization system to the accommodations, care services, program and goods provided to the residents was not communicated to the Resident Council. [s. 228. 3.]

Issued on this 12th day of October, 2016

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

Original report signed by the inspector.