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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 26, 2018	2018_616542_0012	025450-17, 004692-18, 006269-18, 006766-18, 008427-18	Critical Incident System

Licensee/Titulaire de permis

1895357 Ontario Inc.
1202 Highway 94 R.R. #1 Corbeil ON P0H 1K0

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

Nipissing Manor Nursing Care Center
1202 Highway 94 Box 40 Corbeil ON P0H 1K0

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

JENNIFER LAURICELLA (542)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 18 - June 22, 2018.

An "Other" inspection #2018_616542_0013 was conducted concurrently with this Inspection, see the report for further details of non-compliance.

The following intakes were completed during this Critical Incident Inspection;

One intake related to, an injury to a resident where the cause was unknown,

Three intakes, related to falls with injuries and

One intake, related to an illness outbreak.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nurses (RNs), Public Health Nurse, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector conducted a walk through of all resident care areas, observed the provision of care and services to residents, reviewed the health care records of several residents, and reviewed various home policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A) Inspector #542 completed a review of resident #004's health care record. The progress notes located on PointClickCare (PCC) identified documentation of four separate incidents where resident #004 was in a physical altercation (some witnessed and other unwitnessed) with some of their co-residents. These incidents occurred over a month period.

Inspector #542 interviewed RN #100 who was currently responsible for reporting to the Director. They indicated that at the time of the above incidents, the previous Director of Care was responsible for submitting the reports to the Director. RN #100 stated that they were informed that when an incident was not witnessed then the Director was not required to be notified.

Inspector #542 interviewed the Administrator who also indicated that the incidents were not witnessed therefore they did not believe that they were required to notify the Director.

B) Inspector #542 reviewed resident #007's progress notes on PCC and identified documentation from a specific day in March, where resident #007 was involved in a physical altercation with another resident, causing them to fall and sustain an injury.

Inspector #542 was unable to locate any documentation that verified, that the Director was notified of the above incident.

Inspector #542 interviewed RN #100 who was working as the Director of Care on this day. They verified that the Director was not notified regarding the incident involving resident #007 and one of the other residents. RN #100 also verified that they thought it should have been reported to the Director.

Inspector #542 reviewed the home's policy titled, "Zero Tolerance Policy on Abuse and Neglect." Under the heading, "Reporting Abuse and Neglect" it was documented that staff were expected to report any incident or suspected incident of resident abuse or neglect. The policy also included that any case of alleged, suspected or witnessed abuse by anyone, the employee or any other person witnessing or having knowledge of the incident must report the incident immediately to the Administrator, Department Supervisor or Nurse Manager. [s. 24. (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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

A Critical Incident (CI) report was submitted to the Director on a specific day in March, 2018, indicating that the home was placed in a Disease Outbreak by the Public Health Unit. The CI report indicated the total number of residents who were confirmed as experiencing symptoms of an illness. The Public Health Unit was contacted on a specific day in March, 2018 by the home. The outbreak was declared over 18 days later.

Inspector #542 reviewed the home's policy titled, "Outbreak Procedure Checklist" which indicated that the Nurse Manager was to notify the Health Unit when there was a cluster of residents with the same symptoms or an increased number of resident with symptoms or one or more residents with the same symptoms as this could be considered an outbreak.

Inspector #542 reviewed the home's outbreak line listing that was provided by RN #100. A review of the line listing concluded that a resident on a specific resident home area started with illness symptoms on a specific date. Two days later, it was documented on the line listing that three additional residents from the same home area developed symptoms of the same illness. Three days after the first resident with symptoms was identified, an additional resident was placed on the line listing due to signs and symptoms of the same illness. Therefore, over a three day period, a total of five residents from the same home area were experiencing signs and symptoms of a respiratory infection. The home contacted the Public Health Unit, two days after they had five residents experiencing symptoms of the same illness.

Inspector #542 interviewed the Administrator, who confirmed that the Public Health Unit was notified of the potential illness outbreak two days after having five residents identified as experiencing the same illness symptoms.

Inspector #542 interviewed RN #100 who indicated that the Public Health Unit should

have been notified sooner than when they were.

Inspector #542 interviewed the Public Health Nurse that was in contact with the home during this outbreak. They indicated that the home contacted them on the same date identified by the Administrator and RN#100 to inform them of the signs and symptoms that the residents were experiencing. Inspector #542 asked the Public Health Nurse what the procedure was for the reporting requirements regarding a suspected specific illness for long-term care homes. They indicated that it was expected that the home contacted the Public Health Unit when there were two cases of an illness occurring within 48 hours in a geographic area (e.g., unit, floor) or more than one unit having a case of an illness within 48 hours. The Public Health Nurse indicated that the home should have been following a specific guideline.

Inspector #542 reviewed, the guideline which indicated that a "Suspect Outbreak Definition" was: two or more cases of the illness occurring within 48 hours in a geographic area or more than one unit having a case of the illness within 48 hours. [s. 229. (4)]

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 all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

Issued on this 26th day of July, 2018

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

Original report signed by the inspector.