Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 9, 2019	2019_786744_0027	015866-19	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

STEVEN NACCARATO (744)

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): August 20-22, 2019.

One intake was completed during this Critical Incident System (CIS) Inspection:
-One intake related to an unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN) and Physician.

The inspector(s) also conducted daily tours of the resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed of an unexpected or sudden death, including a death resulting from an accident or suicide.

The home submitted a Critical Incident (CI) report to the Director which indicated resident #001 had an unexpected death.

Inspector #744 reviewed the progress notes in resident #001's electronic medical record that described the events prior to the resident's death including the actions of Registered Nurse (RN) #102, Physician #104 and the Substitute Decision Maker (SDM). On a specified date, the Substitute Decision Maker (SDM) for resident #001 was notified by Registered Nurse (RN) #102 that the resident was displaying signs of progressing towards end of life and passed away the same day. RN #102 notified Physician #104 of resident #001's death.

In an interview with Physician #104, they indicated that once they were notified of the death of resident #001, they believed that the death was unexpected.

Inspector #744 interviewed RN #102 who indicated that resident #001 died suddenly on a specified date.

The Inspector reviewed the home's policy titled, "Critical Incidents Mandatory Reporting" revised on January 2018, which indicated that the Director of Care, and Administrator must be notified of an unexpected or sudden death, including a death from an accident or suicide at the time of the incident. The Long-term care (LTC) home must also notify the Ministry of Health and Long-term Care (MOHLTC) immediately upon becoming aware of the incident.

In a further interview with RN #102, they indicated that the Administrator, Director of Care (DOC) and MOHLTC were not notified immediately of the resident's sudden death. RN #102 indicated that they did not know that the death had to be reported immediately and that the RN had made a note of the sudden death in the shift report.

In an interview with Inspector #744, the DOC indicated that staff should have reported the unexpected death to the management team and MOHLTC immediately. The DOC also indicated that they were aware of resident #001's death; however, they were not aware that the death was sudden and unexpected. According to the DOC, they first

became aware that resident #001's death was unexpected on a specified date. After consultation with the Administrator four days later, the DOC made the decision to report the unexpected death to the MOHLTC on that day. The DOC confirmed that staff did not report the unexpected death of resident #001 to the home and the MOHLTC immediately after the resident's death on a specified date and that MOHLTC should have been notified of the resident's death as soon as they were made aware of the unexpected death. [s. 107. (1) 2.]

Issued on this 10th day of September, 2019

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

Original report signed by the inspector.