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
Dec 10, 2019	2019_657681_0029	020446-19	Critical Incident System

Licensee/Titulaire de permis

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

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

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

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

STEPHANIE DONI (681)

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): November 20 - 22, 2019.

One intake related to an incident that caused injury to a resident was inspected during this Critical Incident inspection.

A Complaint inspection, #2019_657681_0028, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Physiotherapist, Registered Nurses (RNs), Physiotherapy Assistant (PTA), Personal Support Workers (PSWs), and residents.

The Inspector also conducted a tour of the resident care areas, reviewed relevant resident care records and home policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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	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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident System (CIS) report was submitted to the Director related to resident #002 falling and sustaining an injury.

Inspector #681 reviewed resident #002's electronic medical record and identified that the resident sustained previous falls, prior to the fall with injury. The Inspector identified that, for one of the resident's previous falls, a specified aspect of the post-fall assessment had not been completed.

During an interview with RN #114, they stated that they did not complete a specified aspect of the post-fall assessment following resident #002's fall, and that it should have been completed.

During an interview with the DOC, they stated that a specified aspect of the post-fall assessment was not completed following resident #002's fall. [s. 49. (2)]

2. In an interview with the DOC, they stated that resident #004 had sustained multiple falls, including two falls during a specified month.

The Inspector reviewed resident #004's electronic medical record and identified that a specified aspect of the post-fall assessment had not been completed for two of the falls that resident #004 had sustained.

During an interview with the DOC, they stated that a specified aspect of the post-fall assessment was not completed for two of resident #004's falls. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee has failed ensure that therapy services for residents of the home that were arranged or provided under section 9 of the Act, included on-site physiotherapy provided to residents based on residents' assessed care needs.

Section 9 of the Long-Term Care Homes Act (LTCHA) indicates that every licensee shall ensure that there is an organized interdisciplinary program with a restorative care philosophy that, where relevant to the resident's assessed care needs, includes, but is not limited to, physiotherapy and other therapy services.

Section 61 (1) of the Ontario Regulation 79/10 indicates that the therapy services referred to in section 59 of the Ontario Regulation and section 9 of the Act are only provided by therapists who have a current certificate of registration with the appropriate college of a regulated health profession.

a) A CIS report was submitted to the Director related to resident #002 falling and sustaining an injury.

Inspector #681 reviewed resident #002's electronic medical record and identified that the resident had sustained previous falls, prior to the fall with injury. The Inspector identified a Fall Report note and a physician progress note, which both indicated that resident #002 had been referred to physiotherapy for an assessment. The Inspector was unable to locate documentation to indicate that resident #002 had been assessed by a physiotherapist.

During an interview with PTA #112, they stated that PT #115 had resigned and the home had been without a physiotherapist for just over one month. The PTA stated that during this time, PT assessments were not completed and no changes to physiotherapy interventions were made.

During an interview with PT #107, they indicated that they started at the home on a specified date in 2019. PT #107 indicated that they assessed residents following a fall and recommended possible interventions to prevent further falls. PT #107 stated that their assessments were documented in the resident's electronic medical record.

During an interview with the DOC, they stated that the home was without a physiotherapist for a specified five week period. The DOC indicated that there was no documentation in resident #002's electronic medical record to support that a physiotherapy assessment had been completed for resident #002.

b) In an interview with the DOC, they stated that resident #004 had sustained multiple falls, including two falls during a specified month.

The Inspector was unable to locate any documentation to indicate that resident #004 had been reassessed by a physiotherapist following either of their two falls that had occurred during the specified month.

During an interview with PTA #112, they stated that resident #004 had not been reassessed by a physiotherapist since sustaining their two falls and that there had not been any changes to the resident's physiotherapy interventions.

During an interview with the DOC, they stated that there was no documentation to indicate that resident #004 had been reassessed by a physiotherapist since sustaining

their two falls in the specified month. [s. 59. (a)]

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 therapy services for residents of the home are arranged or provided under section 9 of the Act that include on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs, to be implemented voluntarily.

WN #3: 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. The licensee has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, that the policy was complied with.

Section 48 (1) of the Ontario Regulation 79/10, indicates that every licensee is required to develop and implement a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, the licensee failed to comply with their policy titled "Nipissing Manor Falls Team", last reviewed November 2019, which was part of the home's fall prevention and management program.

Inspector #681 reviewed the home's Falls Team policy, which identified that the Falls Team was to meet monthly to review all falls, identify further action, and implement additional interventions.

During an interview with the DOC, they stated that the Falls Team met monthly or bi-monthly to review the residents who had fallen. The DOC stated that the Falls Team consisted of the Administrator, DOC, Dietary Manager, Life Enrichment, PTA, and the Restorative Lead. The DOC stated that the last Falls Team meeting occurred approximately three months ago. The DOC verified that none of residents in the home who had fallen since that time had been collaboratively reviewed by the members of the Falls Team. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 11th day of December, 2019

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

Original report signed by the inspector.