Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Oct 28, 2020	2020_657681_0013	016501-20	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), CHAD CAMPS (609), SHANNON RUSSELL (692)

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): October 5-9, 2020.

The following intake was completed during this Critical Incident inspection:

- One intake related to the actions of a staff member which resulted in harm or risk of harm to a resident.

An Other inspection, #2020_657681_0012, and a Complaint inspection, #2020_657681_0014, were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), and Registered Practical Nurses (RPNs).

The Inspectors also conducted a tour of resident care areas, reviewed relevant records and 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:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate action was taken in response to every alleged, suspected or witnessed incident of abuse of a resident that the licensee knew of, or that was reported to the licensee.

The home’s Zero Tolerance of Abuse and Neglect policy indicated that the home's investigation into an incident of resident abuse needed to contain details about what happened, when it happened, who was involved, and any other significant information related to the incident. The DOC verified that they were aware of an allegation of staff to resident abuse, but that they did not fully investigate the allegation.

Sources: The Critical Incident System (CIS) report; the home’s internal investigation notes; the home’s Zero Tolerance of Abuse and Neglect policy; and interviews with the DOC and registered staff.

b) Section 98 of the Ontario Regulation 79/10 indicates that the appropriate police force must be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The Administrator and DOC became aware of an allegation of staff to resident abuse. The home’s internal investigation notes indicated that the police were notified about the incident more than two weeks after the home became aware of the allegation. The DOC verified that the police should have been notified immediately about the allegation of abuse.

Sources: The CIS report; the home’s internal investigation notes; the home’s Zero Tolerance of Abuse and Neglect policy; and an interview with the DOC. (609) [s. 23. (1) (b)]

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 appropriate action is taken in response to every alleged, suspected or witnessed incident of abuse of a resident that the licensee knows of, to be implemented voluntarily.

WN #2: 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 abuse of a resident, that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report related to the allegation of abuse was submitted to the Director more than two weeks after the home became aware of the allegation. The home's Zero Tolerance of Abuse and Neglect policy required allegations of abuse be immediately reported to the Director. The DOC verified that the allegation of resident abuse should have been immediately reported to the Director.

Sources: The CIS report; the home's Zero Tolerance of Abuse and Neglect policy; and an interview with the DOC.

This finding of non-compliance is further evidence to support compliance order #002 that was issued on September 2, 2020, during complaint inspection #2020_752627_0012, which had a compliance due date of October 15, 2020. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint, with respect to a matter that the licensee reported to the Director under section 24 of the Act, was submitted to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

The home submitted a CIS report to the Director, which outlined allegations of staff to resident abuse. A review of the home's internal investigation found a written letter that was forwarded to the home which outlined suspicions of multiple incidents of staff to resident abuse. The DOC verified that the letter was related to the CIS report and that a copy should have been submitted to the Director along with the CIS report.

Sources: The CIS report; the home's internal investigation; and an interview with the DOC. [s. 103. (1)]

Issued on this 29th day of October, 2020

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

Original report signed by the inspector.