Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

Sudbury Service Area Office
159 Cedar Street Suite 403
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Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
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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
Jan 27, 2021	2021_841679_0002	025912-20, 000711-21	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

MICHELLE BERARDI (679), RYAN GOODMURPHY (638)

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): January 11-15, 2021.

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:

- One intake related to an allegation of improper care; and,
- One intake related to the breakdown of the resident to staff communication system.

Follow-Up Inspection #2021_841679_0001 was conducted concurrently with this inspection.

A Compliance Order (CO) related to s. 24 of the Long-Term Care Homes Act, 2007, was identified in this inspection and has been issued in Follow Up Inspection #2021_841679_0001, which was conducted concurrently with this inspection.

Inspector Keara Cronin #759 was present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Manager/Resident Assessment Instruments (RAI) Coordinator, Maintenance Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Life Enrichment Coordinator, Personal Support Workers (PSWs), Physiotherapy Assistants, Ward Clerk, Administrative Assistant, and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, Infection Prevention and Control (IPAC) practices, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 VPC(s)
1 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. 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 staff participated in the implementation of the infection prevention and control (IPAC) program, specifically relating to the use of IPAC signage.

A guidance document titled "Routine Practices and Additional Precautions in All Health Care Settings", by the Provincial Infectious Disease Advisory Committee indicated that a sign which listed the required IPAC precautions should be posted at the entrance to the resident's room or bed space. The Inspector observed four resident rooms which had an isolation caddy present outside the room, as well as signage to indicate how to don and doff personal protective equipment (PPE); however, the Inspector could not locate signage to identify the type of isolation precautions required for any of the four residents reviewed.

The Inspector conducted a review of three resident's care plans and did not locate a focus or interventions related to the need for isolation precautions. Additionally, the care plan for an another resident was reviewed; the care plan indicated that the resident required isolation, however, did not specify the type of required precautions. In an interview with the Nurse Manager, they indicated the need for isolation precautions should be identified in the resident's care plan, as well as directions for the type of isolation required would be located on the doors of the resident rooms. Together, the Nurse Manager and the Inspector observed the resident rooms and could not locate signage to indicate the type of isolation precautions required. The Nurse Manager confirmed the signage should be posted to indicate the type of isolation precautions required.

Sources: Inspector observations on January 13 and 14, 2021; Guidance document titled: "Routine Practices and Additional Precautions in All Health Care Settings", by the Provincial Infectious Disease Advisory Committee dated November 2012; Record reviews including diagnosis, care plan and flow sheets for four residents; Interviews with the Nurse Manager, Director of Care (DOC), and other staff. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from neglect.

Neglect is defined within the Ontario Regulation 79/10, as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

a) A resident appeared to not have received their care, although it had been documented as completed by a Personal Support Worker (PSW). A Registered Nurse (RN) provided an account of what had been reported to them to the DOC the following day. The DOC identified that registered staff were responsible for contacting the after hours line and that the RN should have reported the incident of suspected improper care to the Director.

b) The DOC reviewed the account provided by the RN four days after it was submitted, and reported the incident to the Director. The DOC identified that the investigation began after the incident was reported, and the PSW was interviewed one week after the incident had occurred.

c) The home's Zero Tolerance Policy on Abuse and Neglect indicated that staff must take immediate action where necessary to prevent abuse and neglect, and that this action may include continuous monitoring of the employee involved. A PSW worked in the role of a PSW, providing care to residents, without any additional monitoring on two dates prior to management becoming aware of the suspected improper care. The PSW then continued to work their scheduled shift on one date, after the DOC and Administrator became aware of the incident, without any additional monitoring.

The Inspector interviewed the DOC and inquired about the actions taken throughout this incident. The Inspector questioned whether appropriate action had been taken in response to this incident, the DOC stated “no”.

Sources: “Zero Tolerance Policy on Abuse & Neglect” policy with a review date of August 2020; A CIS report; A resident's progress notes; flow sheets; and interviews with the DOC and other staff. [s. 19. (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 ensuring that all residents of the home are protected from abuse by anyone, and that the residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that medicated creams were stored in an area that was secure and locked.

On two separate occasions, medicated creams were identified in a cart that was unlocked and located in the hallway in a resident home area. The DOC indicated that the medicated creams should not have been kept in the cart and that the staff had been instructed to return medicated creams to registered staff.

Sources: Observations, interview with the DOC and other staff. [759] [s. 129. (1) (a) (ii)]

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 ensuring that drugs are stored in an area or medication cart, that is secured and locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the tub room door on the first floor, was kept closed and locked when it was not being supervised by staff.

The Inspector observed the tub room door on the first floor next to the resident lounge was left propped open while no staff were in the area. The Inspector noted the tub had about one inch of fluid in the bottom and there was disinfectant spray left on the counter. A Registered Practical Nurse (RPN) identified that the tub room door should be kept closed when not being used.

The DOC and Administrator acknowledged they required staff to keep the tub room doors closed and locked when not being supervised by staff and that it was not considered a resident area.

Sources: Inspector observation on January 13, 2021; interviews with a RPN, DOC and other staff. [638] [s. 9. (1) 2.]

Issued on this 29th day of January, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE BERARDI (679), RYAN GOODMURPHY (638)
Inspection No. / No de l'inspection :	2021_841679_0002
Log No. / No de registre :	025912-20, 000711-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 27, 2021
Licensee / Titulaire de permis :	1895357 Ontario Inc. 1202 Highway 94, Corbeil, ON, P0H-1K0
LTC Home / Foyer de SLD :	Nipissing Manor Nursing Care Center 1202 Highway 94, Corbeil, ON, P0H-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Wentworth Graham

To 1895357 Ontario Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229. (4) of Ontario Regulation 79/10.

Specifically, the licensee shall:
a) Ensure that when a resident requires isolation precautions, the appropriate signage is posted to indicate the type of Personal Protective Equipment (PPE) required; and,
b) Review and update the plan of care of each resident who requires isolation precautions to ensure that it includes the need for isolation precautions, including the residents diagnosis, and type of PPE required.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program, specifically relating to the use of IPAC signage.

A guidance document titled "Routine Practices and Additional Precautions in All Health Care Settings", by the Provincial Infectious Disease Advisory Committee indicated that a sign which listed the required IPAC precautions should be posted at the entrance to the resident's room or bed space. The Inspector observed four resident rooms which had an isolation caddy present outside the room, as well as signage to indicate how to don and doff personal protective equipment (PPE); however, the Inspector could not locate signage to identify the type of isolation precautions required for any of the four residents reviewed.

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required precautions. In an interview with the Nurse Manager, they indicated the need for isolation precautions should be identified in the resident's care plan, as well as directions for the type of isolation required would be located on the doors of the resident rooms. Together, the Nurse Manager and the Inspector observed the resident rooms and could not locate signage to indicate the type of isolation precautions required. The Nurse Manager confirmed the signage should be posted to indicate the type of isolation precautions required.

Sources: Inspector observations on January 13 and 14, 2021; Guidance document titled: "Routine Practices and Additional Precautions in All Health Care Settings", by the Provincial Infectious Disease Advisory Committee dated November 2012; Record reviews including diagnosis, care plan and flow sheets for four residents; Interviews with the Nurse Manager, Director of Care (DOC), and other staff.

An order was made by taking the following factors into account:

Severity: There was minimal risk identified, as PPE and instructions to don and doff were identified, but the type of PPE required was not.

Scope: The scope of this non-compliance was widespread as it affected four out of four residents reviewed who required isolation precautions.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with Ontario Regulation 79/10 s. 229, and two Voluntary Plans of Correction (VPCs) were issued to the home. (679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of January, 2021

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Michelle Berardi

Service Area Office / Bureau régional de services : Sudbury Service Area Office