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
Aug 10, 2021	2021_908642_0002	007088-21, 009570-21	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

AMY GEAUVREAU (642)

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): July 26-29, 2021.

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

One Critical incident, that was submitted to the Director regarding resident to resident alleged physical abuse which caused an injury.

One Critical Incident, that was submitted to the Director regarding alleged neglect related to staff not providing medication during end of life care.

A concurrent Complaint Inspection #2021_908642_0001, was conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC) and the Infection Prevention Lead, Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Dietary Cook, Dietary Aids, Personal Support Workers (PSWs), Housekeeper, family members, and residents.

The Inspector also conducted a daily tour of the resident care areas, reviewed relevant resident records and policies, the Infection Prevention and Control (IPAC) practices were reviewed, investigations notes and interviews and observed resident rooms, resident common areas, dining areas, reviewed recorded temperatures, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **1 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 O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who required end-of-life care, received care in a manner that met their needs.

A review of a resident's medical file identified a written order for palliative care the Physician had signed, which included an order for a specific medication.

A review of this resident's progress notes, showed that registered nursing staff trialed different doses of the medication and found that a certain dose helped the resident rest comfortably.

On a subsequent shift, a RN provided a different dose of the medication. The resident's SDM requested the prior dose be administered, but the RN refused stating the resident was comfortable at that time.

The SDM was concerned because they wanted the resident to be comfortable and there were signs that indicated the resident was not comfortable.

The Administrator stated the RN should have implemented the SDM’s request to increase the medication as requested, since it was in the Physician orders.

Sources: Critical incident report; written medical order from Physician titled, End Stage Palliative Care Comfort Measures; resident's progress notes; Medication Administration Record (MAR); Interviews with Administrator, RN’s, RPN, and other staff. [s. 42.]

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 residents requiring the end-of-life care receive care in a manner that meets their needs, to be implemented voluntarily.

Issued on this 13th day of August, 2021

[redacted]

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

Original report signed by the inspector.