Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: November 10, 2022	
Inspection Number: 2022-1006-0001	
Inspection Type: Critical Incident System	
Licensee: 1895357 Ontario Inc.	
Long Term Care Home and City: Nipissing Manor Nursing Care Center, Corbeil	
Lead Inspector Ryan Goodmurphy (638)	**Inspector Digital Signature** Ryan C Goodmurphy Digitally signed by Ryan C Goodmurphy Date: 2022.11.10 11:28:06 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 1 - 4, 2022.

The following intake(s) were inspected:

- One intake which was related to an alleged incident of staff to resident abuse.
- One intake which was related to a fall resulting in injury.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 3 (1) 11. iv.

The licensee has failed to ensure that a resident's rights were fully respected and promoted, specifically, to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential.

A staff member approached two staff while they were providing care to residents, pulled back the privacy curtain and discussed another resident's health status. One resident was able to understand what staff were being told. The Assistant Administrator identified that one of the residents could hear and understand and therefore speaking about another resident's status could be a breach of their personal health information.

Staff failed to protect the personal health information of a resident when they spoke to staff about a resident's health status in front of other residents.

Sources: Resident health care records; investigation notes; interviews with Assistant Administrator, Director of Care and other staff. [638]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

A resident required a safety intervention while using their mobility aid. On a specific date, the resident was using their mobility aid and staff did not implement the resident's safety intervention. The resident sustained an injury. The Assistant Administrator identified that the resident's safety interventions were outlined within the resident's plan of care and that staff were required to implement the interventions.

Staff failed to provide the resident with their safety intervention which resulted in an injury to the resident.

Sources: The resident's health care records; investigation notes; and interviews with the Assistant Administrator, Director of Care and other staff. [638]

WRITTEN NOTIFICATION: Housekeeping

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 93 (2) (b) (iii)

The licensee has failed to ensure that cleaning and disinfection of contact surfaces was done using, at a minimum, a low-level disinfectant.

Housekeeping staff identified that when the home was not in outbreak, they used a specific product for cleaning contact surfaces. The product's Material Safety Data Sheet recommended the usage of this product as a sanitizer and not as a disinfectant.

The home using a sanitizer to clean contact surfaces instead of a disinfectant placed the residents at risk of exposure to bacteria or viruses, which may not be removed by a sanitizer.

Sources: The cleaning product's Material Safety Data Sheet; the cleaning product's label; interviews with housekeeping lead and other staff. [638]