

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

Sudbury Service Area Office  
159 Cedar Street Suite 403  
SUDBURY ON P3E 6A5  
Telephone: (705) 564-3130  
Facsimile: (705) 564-3133

Bureau régional de services de  
Sudbury  
159, rue Cedar Bureau 403  
SUDBURY ON P3E 6A5  
Téléphone: (705) 564-3130  
Télécopieur: (705) 564-3133

**Public Copy/Copie du rapport public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jul 6, 2021	2021_901759_0001	004080-21, 006397- 21, 006903-21, 007036-21, 007543- 21, 007747-21	Critical Incident System

**Licensee/Titulaire de permis**

The West Nipissing General Hospital  
725 chemin Coursol Road Sturgeon Falls ON P2B 2Y6

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

The West Nipissing General Hospital  
725 chemin Coursol Road Sturgeon Falls ON P2B 2Y6

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

KEARA CRONIN (759), RYAN GOODMURPHY (638), STEVEN NACCARATO (744)

**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): June 16-18, and 21-25, 2021.**

**The following intakes were inspected upon during this Critical Incident System Inspection:**

- Four intakes relating to incidents of responsive behaviours among two residents;**
- Two intakes relating to alleged incidents of staff to resident abuse**

**Follow Up Inspection #2021\_901759\_0002 and Other Inspection #2021\_901759\_0003 were also conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Care, the Clinical Nurse Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), The Behavioural Supports Ontario (BSO) Lead, Screeners, the Food Services Manager, the Infection Prevention and Control (IPAC) Lead, Maintenance Workers, Physiotherapy Assistants (PTA), Housekeepers, and residents.**

**The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed infection prevention and control (IPAC) practices, reviewed cooling and air temperature requirements, reviewed relevant health care records, reviewed the home's internal investigation notes, and reviewed licensee policies and procedures.**

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

**Infection Prevention and Control  
Prevention of Abuse, Neglect and Retaliation  
Responsive Behaviours  
Safe and Secure Home**

**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)**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<b>Legend</b>	<b>Légende</b>
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.

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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20.  
Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with, related to the immediate reporting of an alleged incident of abuse towards a resident.

The home's Zero Tolerance of Abuse and Neglect policy required staff to immediately report any alleged, suspected or witnessed incident of abuse of a resident by anyone to the unit manager or delegate.

A Critical Incident System (CIS) report was submitted to the Director regarding an allegation of staff to resident abuse.

A review of the home's investigation notes indicated that an incident of alleged abuse was not reported to the manager until the following day.

In an interview with the Clinical Nurse Manager, they indicated that staff were to report suspected abuse to the manager and that the PSW did not report the concern immediately.

Sources: The home's policy titled Zero Tolerance of Abuse and Neglect (last revised January 28, 2019); A CIS Report; the home's investigation notes; and interviews with the Clinical Nurse Manager and other staff relevant members. [s. 20. (1)]

2. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with, related to the reporting of an alleged abuse of a resident.

A Critical Incident System (CIS) report was submitted to the Director regarding an allegation of staff to resident abuse.

In an interview with the Clinical Nurse Manager, they indicated that they overheard a PSW stating that a resident had accused a PSW of abuse.

A review of the home's investigation notes indicated that allegations of abuse of the resident were known to five PSWs months prior to the CIS report; however, this incident was not reported to the manager.

The Clinical Nurse Manager further indicated that all staff members who had knowledge of the allegation were expected to report to the manager immediately.

Sources: The home's policy titled Zero Tolerance of Abuse and Neglect (last revised January 28, 2019); a CIS report; the home's investigation notes; and interviews with the Clinical Nurse Manager and other relevant staff members. [s. 20. (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 to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements**

**Specifically failed to comply with the following:**

**s. 20. (1.1) The heat related illness prevention and management plan must, at a minimum,**

**(a) identify specific risk factors that may lead to heat related illness and require staff to regularly monitor whether residents are exposed to such risk factors and take appropriate actions in response; O. Reg. 79/10, s. 20 (1.1).**

**(b) identify symptoms of heat related illness and require staff to regularly monitor whether residents exhibit those symptoms and take appropriate actions in response; O. Reg. 79/10, s. 20 (1.1).**

**(c) identify specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents; O. Reg. 79/10, s. 20 (1.1).**

**(d) include the use of appropriate cooling systems, equipment and other resources, as necessary, to protect residents from heat related illness; and O. Reg. 79/10, s. 20 (1.1).**

**(e) include a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate. O. Reg. 79/10, s. 20 (1.1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the heat related illness prevention and management plan identified symptoms of heat related illness and included a protocol for appropriately communicating the heat related illness prevention and management plan to the required individuals.

A memo titled “Amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007 related to enhanced cooling requirements” was sent on April 1, 2021, with an effective date of May 15, 2021.

The West Nipissing General Hospital Preparation for Extreme Heat plan was reviewed and the Inspector was unable to identify any specifics related to symptoms of heat related illness or a communication protocol to communicate the plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council and the Family Council of the home.

The Inspector reviewed the minimum requirements of the heat related illness prevention and management plan with the CEO, DOC and LTC Unit Manager related to identifying symptoms of heat related illness as well as the requirement for a protocol to be included in the plan for appropriately communicating the heat related illness prevention and management plan to the required individuals. The CEO identified there were a few gaps in the plan that they could easily fix.

Sources: West Nipissing General Hospital Preparation for Extreme Heat plan; April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007 related to enhanced cooling requirements; and interviews with the CEO, DOC, LTC Unit Manager and other relevant staff members. [s. 20. (1.1)]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature**

**Specifically failed to comply with the following:**

**s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:**

**1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).**

**s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).**

**Findings/Faits saillants :**



1. The licensee has failed to ensure that air temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

A maintenance staff identified that they monitored air temperature in the corridor in front of the nurses' station as there was a thermometer placed in that location. The maintenance staff identified that no air temperatures were checked specifically in resident rooms.

Sources: West Nipissing General Hospital Temperature Log – LTC; April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007 related to enhanced cooling requirements; and Interviews with maintenance staff and other staff members. [s. 21. (2) 1.]

2. The licensee has failed to ensure the air temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The Inspector reviewed temperature logs which identified that temperatures were taken twice daily at 0700 hours and 1500 hours.

A maintenance staff identified that they check air temperature in the long-term care home first thing in morning and again in the afternoon. The CEO identified air temperature checks were done twice a day on the long-term care home side and not checked on nights.

Sources: West Nipissing General Hospital Temperature Log – LTC; April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007 related to enhanced cooling requirements; and Interviews with the CEO and other staff members. [s. 21. (3)]

**Issued on this 7th day of July, 2021**

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

**Original report signed by the inspector.**