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

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

Original Public Report

Report Issue Date May 10, 2022
Inspection Number 2022_1469_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Algoma Manor Nursing Home

Long-Term Care Home and City
Algoma Manor Nursing Home,
Thessalon, ON
POR 1L0

Lisa Moore
2022.05.11 11:46:58 -04'00'

Lead Inspector
Lisa Moore #613

Inspector Digital Signature

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 26 – 28, 2022.

The following intake(s) were inspected:

- Intake (Complaint) related to concerns regarding the provision of care following a resident fall; and,

- Intake related to a resident fall resulting in a change in status and transfer to the hospital.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)

INSPECTION RESULTS

WRITTEN NOTIFICATION: POLICIES

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 11 (1) (b)

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

Rationale and Summary: In accordance with O. Reg. 246/22, s. 54 (1)., the licensee must ensure the falls prevention and management program, at a minimum, provided strategies to reduce or mitigate falls and included the monitoring of residents.

Specifically, staff did not comply with the following of the licensee's Head Injury Routine policy.

The licensee's policy identified the Head Injury Routine (HIR) would be implemented to initiate a thorough assessment, monitoring and early detection of complications following a head injury or possible head injury, ensuring documentation reflected time specific and accurate documentation.

A resident had a witnessed fall that resulted in an injury and transfer to the hospital, where they passed away.

The resident's Head Injury Routine form identified that several registered staff did not complete an accurate or thorough assessment of the resident or complete the required documentation at most of the scheduled times. The resident was receiving a specific medication, which required additional monitoring and frequencies of checks when on HIR, which was not done by the registered staff.

The Director of Care (DOC) confirmed that several registered staff did not comply with the licensee's HIR policy.

The home's failure to ensure that the registered staff complied with the HIR policy put a resident at actual risk and harm as registered staff were not completing required assessments at scheduled times to identify changes to the resident's health status.

Sources: Complainant; CI report; the licensee's Head Injury Routine (HIR) policy; resident's progress notes and HIR form and interviews with the DOC and RPNs.

Inspector #613

WRITTEN NOTIFICATION: CRITICAL INCIDENT REPORTS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 115 (5) 2. ii

The licensee has failed to make a report to the Director setting out the name of any staff members or other persons who were present at or discovered the incident under subsection (4), within 10 days of becoming aware of the incident.

Rational and Summary: A Critical Incident (CI) report was submitted to the Director, identifying a resident had an incident that caused an injury resulting in a significant change in the resident's health condition and transfer to the hospital. The CI report did not identify the names of any staff members or other persons who were present at or discovered the incident.

The DOC confirmed the CI report did not identify the staff members name who discovered the resident.

Sources: CI report and interview with the DOC.

Inspector #613

WRITTEN NOTIFICATION: CRITICAL INCIDENT REPORTS

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 115 (5) 4. i

The licensee has failed to make a report to the Director setting out the analysis and follow-up action, including the immediate actions that had been taken to prevent recurrence under subsection (4), within 10 days of becoming aware of the incident.

Rational and Summary: A Critical Incident (CI) report was submitted to the Director, identifying a resident had an incident that caused an injury resulting in a significant change in the resident's health condition and transfer to the hospital. The CI report did not identify the immediate actions that had been taken to prevent recurrence.

The DOC confirmed the CI report did not identify the immediate action that had been taken to prevent recurrence.

Sources: CI report and interview with the DOC.

Inspector #613

WRITTEN NOTIFICATION: CRITICAL INCIDENT REPORTS

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 115 (5) 4. ii

The licensee has failed to make a report to the Director setting out the analysis and follow-up action, including the long-term actions planned to correct the situation and prevent recurrence under subsection (4), within 10 days of becoming aware of the incident.

Rational and Summary: A Critical Incident (CI) report was submitted to the Director, identifying a resident had an incident that caused an injury resulting in a significant change in the resident's health condition and transfer to the hospital. The CI report did not identify the long-term actions planned to correct the situation and prevent recurrence. The CI report was amended on a later date and still did not include the home's analysis and follow up action to the incident.

The DOC confirmed the CI report did not identify the long-term actions planned to correct the situation and prevent recurrence.

Sources: CI report and interview with the DOC.

Inspector #613

COMPLIANCE ORDER CO#001: POLICIES

CO#001 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg 246/22 s. 11 (1) (b)

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (b) prepare, submit and implement a written plan for achieving compliance with a requirement under this Act. 2021

Compliance Order [FLTCA 2021, s. 155 (1)]
The Licensee has failed to comply with O. Reg. 246/22 s. 11 (1) (b)

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

Compliance Plan [*FLTCA, 2021, s. 155 (1) (b)*]

The licensee shall prepare, submit and implement a plan to ensure registered staff are following the home's Head Injury Routine policy when a Head Injury Routine (HIR) is initiated for resident's unwitnessed falls and witnessed falls that result in a possible head injury.

The plan must include but is not limited to:

-The type of retraining involved, including who will be responsible for the retraining and when it will be completed;

-The person(s) responsible for monitoring that the policy is being complied with, the frequency of monitoring and how it will be documented;

-The person(s) responsible for implementing an action plan if monitoring demonstrates the policy is not complied with; and

-Actions to address sustainability once the home has been successful in ensuring compliance with this policy.

Please submit the written plan for achieving compliance for inspection 2021_1469_0001 to Lisa Moore, LTC Homes Inspector, MLTC, by email to SAO.generalemail@ontario.ca by May 23, 2022.

Please ensure that the submitted written plan does not contain any PI/PHI.

This plan shall be implemented by the compliance due date: June 3, 2022.

Grounds

Non-compliance with: O. Reg. 246/22 s. 11 (1) (b)

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Sources: Complainant; CI report; the licensee's Head Injury Routine (HIR) policy; resident's progress notes and HIR form and interviews with the DOC and RPNs.

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This order must be complied with by June 3, 2022

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Sudbury Service Area Office
159 Cedar Street, Suite 403
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SudburySAO.moh@ontario.ca

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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