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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
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Public Copy/Copie du rapport public

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, 2020	2020_740621_0011	013770-20	Other

Licensee/Titulaire de permis

Nipigon District Memorial Hospital
125 Hogan Road NIPIGON ON P0T 2J0

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

Nipigon District Memorial Hospital
125 Hogan Road P.O. Box 37 NIPIGON ON P0T 2J0

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

JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): July 24, 27 - 28, 2020.

The following intake was inspected during this Other inspection:
- One intake, related the home's bed license and occupancy status.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Nurse Manager (NM), the Long-Term Care (LTC) Lead, the Manager of Placement, Home and Community Care (PHC) at the North West Local Health Integrated Network (NWLHIN), and the Senior Program Consultant at the Ministry of Long-Term Care (MLTC) Licensing Unit.

The Inspector also reviewed the home's bed license, relevant correspondence between the home and licensing unit, bed notification documentation, relevant resident health care records, and specific licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the licensee determines that the injury to a resident has resulted in a significant change in the resident's health condition, or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence for the incident, and follow up with the report required under subsection (4).

During interviews with the home's Nurse Manager and LTC Lead, it was identified that the home was not submitting mandatory Critical Incident System (CIS) reports for residents who resided in a specific bed type, and who were involved in incidents where a resident sustained an injury and had a significant change in health status. Specifically, the Nurse Manager and LTC Lead identified that on a specific date in July 2020, resident #001, who resided in a specified bed type, sustained a fall with injury. Although it was identified that the resident was immediately assessed, with appropriate diagnostic care and treatment provided, a mandatory CIS report to the Director was not completed within the required three business days, or anytime thereafter. The Nurse Manager and LTC Lead identified that they understood that CIS reporting was not required for the particular bed type, but were not aware that by placing a LTC resident into the identified bed type, that the same reporting requirements under the Long-Term Care Homes Act (LTHCA), 2007, and Ontario Regulation (O. Reg) 79/10 came into effect for these residents as well. The Nurse Manager identified that they would have been the person responsible for completing the CIS report for this resident, and that it had not occurred. [s. 107. (3.1) (b)]

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. 104. Beds allowed under licence

Specifically failed to comply with the following:

s. 104. (1) A licensee shall not operate more beds in a long-term care home than are allowed under the licence for the home or under the terms of a temporary licence issued under section 111 or a temporary emergency licence issued under section 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that the long-term care home was not operating more beds than were allowed under the license for the home, or under the terms of a temporary license issued under section 111 or that were authorized under section 113.

A Service Area Office (SAO) inspection was initiated to inspect on concerns brought forwarded, which identified that the home had admitted more residents than they had licensed long-term care (LTC) beds to accommodate.

During a review of correspondence from the Ministry of Long-Term Care (MLTC) Licensing Unit, it indicated that through conversation with the home's Administrator on a specific day in July 2020, it was identified that the home had a license for a specified number of LTC beds, but had a greater number of LTC residents admitted. The home's Administrator reported that all residents in the home were accepted through the same LTC placement process between the home and the Northwest Local Health Integrated Network (NWLHIN), and that a specific number of additional LTC residents were admitted to the home and placed in a particular number of unlicensed beds.

During a subsequent interview with the Licensing Unit Senior Program Consultant, they reported to Inspector #621 that following receipt of the home's bed license renewal (for continued operation of a specific number and type of licensed beds), the home wanted to clarify their existing bed and resident counts, as they were different than what was identified on the bed license. The Senior Program Consultant identified that the Administrator reported that they had a specified number of residents admitted, in spite of having fewer licensed LTC beds to operate within the home.

During an interview with the Nurse Manager, they reported to Inspector #621 that, as of a specific date in July 2020, there were a specified number of LTC residents admitted to the home, with a total bed complement of another specified number. When the Inspector inquired as to how many beds the home had that were licensed LTC beds, the Nurse Manager reported that they didn't know. Further the Nurse Manager indicated that of the total beds in the home, a specific number were a particular type of unlicensed bed, and all of the beds of this type were occupied by residents admitted to LTC. When the Inspector inquired whether all residents occupying the specific unlicensed bed type were provided the same level of care as the remaining LTC resident population, the Nurse Manager reported that the only exception was that residents in the specified unlicensed bed type did not have mandatory CIS reports completed, (when a reportable incident

occurred under the LTCHA 2007, or O. Reg 79/10 legislation), as they had been previously told that these beds were not LTC beds, and consequently, did not fall under the LTC legislative requirements like the other licensed beds. When the Inspector inquired as to how long the home had been admitting LTC residents into this specific unlicensed bed type, the Nurse Manager indicated that it had been occurring since at least a particular month in 2018, but understood that this practice had been going on for much longer. When the Inspector asked if there had been any known incidents that led to a significant change in status for the residents occupying these specific unlicensed beds, the Nurse Manager indicated that resident #001 had a fall on a day in July 2020, where they sustained a fall with injury. The Nurse Manager confirmed that a mandatory CIS report had not been submitted to the Director for this incident.

During a subsequent interview with the Nurse Manager, to discuss the process involved for offering beds to the NWLHIN for placement, they identified that when a bed was available in the home, they completed an electronic bed notification form through the a specified computer program interfaced with the NWLHIN. When the Inspector inquired if they identified on the form, whether the bed offer was for a licensed LTC bed or another specific bed type, the Nurse Manager reported that they reported on the form that the bed type vacancy was for a specific type of LTC bed, regardless of whether the bed offer was for a licensed LTC bed or one of the specified unlicensed beds in the home. Further, the Nurse Manager provided to the Inspector the names, date of admission and room numbers of each of the identified LTC residents who, at the time of inspection, occupied one of the unlicensed beds within the home.

During an interview with the LTC Lead, they reported to the Inspector that the home had a specific number of LTC residents admitted into the home, with a particular number of these residents residing in licensed beds, and the remaining residents residing in a specified unlicensed bed type. The LTC Lead indicated that of the residents occupying the unlicensed beds, a certain number were admitted directly to the bed during the bed placement process with the NWLHIN. However, the LTC Lead identified that the remaining residents (who were originally admitted to a LTC bed), at some time during the admission had become more complex in their care, so with a physician’s order these residents were discharged from their LTC bed and internally transferred to one of the empty beds of a specific bed type. The LTC Lead further identified that the practice of using unlicensed beds inter-changeably with licensed LTC beds, had been going on since the new hospital had opened, with then Chief Executive Offer (CEO) #105 and Director of Care (DOC) #106 directing the home’s staff to treat the unlicensed type beds the same as LTC beds, and intermix these beds throughout the LTC home areas within

the facility. The LTC Lead confirmed that all beds in the home continued to be used for LTC residents, regardless of whether they were licensed or unlicensed beds, and at no point in all the years that this had been occurring, had anyone from the former Community Care Access Centre (CCAC) or current NWLHIN questioned the home's practice. Further the LTC Lead reported that the CCAC/NWLHIN was aware of what the home was doing.

During an interview with the Manager of Placement, Home and Community Care (PHC) at the NWLHIN, they identified that since 2001, they oversaw the placement coordinator activities within the NWLHIN, and that the home and NWLHIN interfaced placement activities through a specified computer software database. They indicated to Inspector #621 that placement of an applicant was made based on the information provided by the home through this electronic portal. On review of their internal records, the Manager of PHC reported that the home had a specified number of beds, with a certain number being licensed LTC beds, and the remaining being an unlicensed bed type. When the Inspector inquired how the NWLHIN tracked how many residents were in the home at any given time, they reported that they didn't always know, and that when the home reported to the NWLHIN that they have a bed vacancy, they trusted that the bed information provided in the computer portal by the home, was accurate. When the Inspector inquired how long their records identified that the home had a higher bed count than the count identified on the home's bed license, the Manager of PHC indicated that they weren't sure, but confirmed that the unlicensed bed type in question, did not meet bed licensing requirements under the long-term care legislation, and that they had been aware that the home had been treating all the beds in their home as LTC beds.

During an interview with the home's Administrator, they reported to Inspector #621 that they noticed a discrepancy in their actual resident census and the license of the home. They had identified that the practice of placing LTC residents into a specified bed type in the home had started long before their taking the role of Administrator for the home. Additionally, they identified that while they did have questions regarding the operation of the specified bed type in question, including why CIS reports were not completed for residents occupying those beds, they understood that these particular beds in the home were a unique situation, and treated differently than other homes with the same bed type within the region. The Administrator reported that the NWLHIN had never questioned the home and had authorized the admission of LTC applicants to the home's unlicensed beds. The Administrator confirmed to the Inspector that up until the time of inspection, the home had treated all the beds, including the identified unlicensed beds in their home, as LTC beds. [s. 104. (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 the long-term care home is not operating more beds than are allowed under the license for the home, or under the terms of a temporary license issued under section 111 or that are authorized under section 113, to be implemented voluntarily.

Issued on this 13th day of August, 2020

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

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

Ordre(s) de l'inspecteur

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) :	JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2020_740621_0011
Log No. / No de registre :	013770-20
Type of Inspection / Genre d'inspection:	Other
Report Date(s) / Date(s) du Rapport :	Aug 10, 2020
Licensee / Titulaire de permis :	Nipigon District Memorial Hospital 125 Hogan Road, NIPIGON, ON, P0T-2J0
LTC Home / Foyer de SLD :	Nipigon District Memorial Hospital 125 Hogan Road, P.O. Box 37, NIPIGON, ON, P0T-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy Covino

To Nipigon District Memorial Hospital, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Order / Ordre :

The licensee must be compliant with r.107 (3.1) of Ontario Regulation (O.Reg) 79/10.
Specifically, the licensee must:

Ensure that all long-term care residents residing in the home, including those residing in specified unlicensed beds, are care managed by the home consistent with the Ontario Long-Term Care Homes Act (LTCHA),2007., and O.Reg 79/10 legislative requirements. This includes completion of any mandatory Critical Incident System (CIS) reporting requirements as identified.

Grounds / Motifs :

1. The licensee has failed to ensure that the long-term care home was not operating more beds than were allowed under the license for the home, or under the terms of a temporary license issued under section 111 or that were authorized under section 113.

A Service Area Office (SAO) inspection was initiated to inspect on concerns brought forwarded, which identified that the home had admitted more residents

than they had licensed long-term care (LTC) beds to accommodate.

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During an interview with the LTC Lead, they reported to the Inspector that the home had a specific number of LTC residents admitted into the home, with a particular number of these residents residing in licensed beds, and the remaining residents residing in a specified unlicensed bed type. The LTC Lead indicated that of the residents occupying the unlicensed beds, a certain number were admitted directly to the bed during the bed placement process with the NWLHIN. However, the LTC Lead identified that the remaining residents (who were originally admitted to a LTC bed), at some time during the admission had become more complex in their care, so with a physician's order these residents were discharged from their LTC bed and internally transferred to one of the empty beds of a specific bed type. The LTC Lead further identified that the practice of using unlicensed beds inter-changeably with licensed LTC beds, had been going on since the new hospital had opened, with then Chief Executive Offer (CEO) #105 and Director of Care (DOC) #106 directing the home's staff to

treat the unlicensed type beds the same as LTC beds, and intermix these beds throughout the LTC home areas within the facility. The LTC Lead confirmed that all beds in the home continued to be used for LTC residents, regardless of whether they were licensed or unlicensed beds, and at no point in all the years that this had been occurring, had anyone from the former Community Care Access Centre (CCAC) or current NWLHIN questioned the home's practice. Further the LTC Lead reported that the CCAC/NWLHIN was aware of what the home was doing.

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were a unique situation, and treated differently than other homes with the same bed type within the region. The Administrator reported that the NWLHIN had never questioned the home and had authorized the admission of LTC applicants to the home's unlicensed beds. The Administrator confirmed to the Inspector that up until the time of inspection, the home had treated all the beds, including the identified unlicensed beds in their home, as LTC beds.

The severity of this issue was determined to be a level three, as there was a actual harm or risk to residents of the home. The scope of the issue was a level one, with one out of seven LTC residents residing in an unlicensed bed, found to have sustained an incident with injury, for which resulted in a significant change in status. The home had a level two compliance history, as there was previous non-compliance with a different subsection of the O.Reg 79/10, within the previous 36 months. (621)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2020

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:

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

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 10th day of August, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Kuorikoski

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