Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 14, 2017	2017_633577_0013	032513-16	Complaint

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

DEBBIE WARPULA (577)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): This was an Off-site Inspection conducted June 27-July 11, 2017.

The following intake was inspected: One log related to a complaint concerning the discharge of a resident.

During the course of the inspection, the inspector conducted a record review of progress notes, concerns and compliments policy, letters of correspondence and complaint letters.

During the course of the inspection, the inspector(s) spoke with the Acting Chief Nursing Officer (ACNO), Nurse Manager, Placement Manager for Community Care Access Centre (CCAC), Care Coordinator for Community Care Access Centre, Waitlist Planner for Community Care Access Centre and a Family Member.

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

During the course of this inspection, Non-Compliances were issued.
- **4 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	Legendé 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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the 24 hour care plan identified any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

A complaint was received by the Director in November 2016, concerning the management of resident #001's care and admission to Long-Term Care (LTC) at the Nipigon District Memorial Hospital.

Inspector #577 conducted a record review of resident #001's progress notes in June 2016, which indicated they were admitted to LTC and then discharged to an acute care facility.

A review of the progress notes during resident #001's admission, revealed frequent responsive behaviours.

During a record review of resident's admission 24 hour care plan, Inspector #577 found no indications of resident #001's specific responsive behaviours.

During an interview with the Chief Nursing Officer, they reported that registered staff were responsible for updating the 24 hour care plans. They further confirmed that specific interventions to manage the resident's responsive behaviours should have been included in the care plan for resident #001. [s. 24. (2) 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 24 hour care plan identifies any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written complaints concerning the care of a resident or the operation of the long-term care home were immediately forwarded to the Director.

A complaint was received by the Director on November 15, 2016, concerning the management of resident #001's care and admission to LTC at the Nipigon District Memorial Hospital.

Two letters dated in October 2016, were submitted to the home in October 2016, by two family members of the resident. The complaint letters alleged that the Nurse Manager contacted the Substitute Decision Maker (SDM) two days following admission and told them that they needed to bring the resident home, any future LTC was terminated as they did not have the staff to manage the resident's behavior. Further, the SDM was allegedly denied the opportunity to speak with the physician when requested, was informed that admission was a trial and resident #001 would not be admitted to LTC.

During an interview with the Nurse Manager on July 7, 2016, they confirmed with Inspector #577 that the complaint letters that were received by the home in October 2016, were not forwarded to the Director. [s. 22. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that when they withhold approval for admission, that they gave persons described in subsection (10) a written notice that set out, the ground or grounds on which the licensee was withholding approval; a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval; and contact information for the Director.

A complaint was received by the Director in November 2016, concerning resident #001's admission to the home.

Inspector #577 reviewed a letter dated September 2016, addressed to the SDM from the Community Care Access Centre (CCAC). The letter indicated that resident #001 had been determined eligible for LTC and their application had been sent to Nipigon District Memorial Hospital. The Inspector reviewed an additional letter dated September 16, 2016, addressed to the SDM from CCAC which indicated that Nipigon District Memorial Hospital had accepted resident #001 for October 2016.

Inspector #577 conducted a record review of resident #001's progress notes on June 29, 2017, which indicated they were admitted in October 2016, and discharged to an acute care facility shortly thereafter.

Inspector #577 reviewed a letter dated October 2016, from the Nurse Manager addressed to the resident's SDM. The letter indicated that Nipigon District Memorial Hospital was not able to accept resident #001 onto the waitlist for long term placement

due to their responsive behaviors. The letter did not include a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care; further, the letter did not include an explanation of how the supporting facts justified the reason to withhold approval, nor contact information for the Director.

During an interview with Care Coordinator for CCAC on July 11, 2017, they confirmed that they had not received any written correspondence from the licensee concerning withholding approval for admission. They reported that they should have been notified through written correspondence from the home but it was verbally discussed with the Nurse Manager.

During an interview with the Nurse Manager on June 28, 2017, they reported to the Inspector that resident #001 was admitted and due to their responsive behaviors, they were a safety and security issue. They also confirmed that they forwarded a letter dated October 5, 2016, to the resident's SDM denying LTC placement due to responsive behaviours, with no further details.

During an interview with the CCAC Placement Manager on July 12, 2017, they confirmed that they had not received any written notice concerning withholding approval for admission from the licensee. [s. 44. (9)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 162. Approval by licensee

Specifically failed to comply with the following:

s. 162. (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act. O. Reg. 79/10, s. 162 (3).
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act. O. Reg. 79/10, s. 162 (3).

Findings/Faits saillants :

1. Subject to subsections (4) and (5), the licensee failed to ensure that within five business days after receiving the request mentioned in clause (1) (b), did one of the following: Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act, or if the licensee was withheld the approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act.

A complaint was received by the Director in November 2016, concerning the licensee withholding approval of resident #001's admission to the home.

Inspector #577 reviewed a letter from CCAC that was forwarded to resident #001's SDM and the licensee, as follows:
-letter dated September 2016, resident #001 had been determined eligible for LTC and their application had been sent to Nipigon District Memorial Hospital.

Inspector #577 reviewed a letter dated October 2016, from the Nurse Manager addressed to the resident's POA. The letter indicated that Nipigon District Memorial Hospital was not able to accept resident #001 onto the waitlist for LTC placement due to their responsive behavior.

During an interview with the Care Coordinator for CCAC on July 11, 2017, they confirmed that they had not received any written correspondence within five business days from the licensee concerning withholding approval for admission. They reported that they should have been notified through written correspondence from the home but it was discussed verbally with the nurse Manager.

During an interview with the Nurse Manager on June 28, 2017, they reported to the Inspector that they forwarded a letter dated October 2016, to the resident's SDM denying LTC placement due to responsive behaviours, 30 days after they had received the request for placement to LTC. On July 5, 2017, they stated that they faxed that letter to CCAC on October 2016, 30 days after the request for LTC placement to the home was made and that written notice was not forwarded to the Director.

During an interview with the CCAC Placement Manager on July 5, 2017, they reported that CCAC approved resident #001 to be eligible for LTC placement at Nipigon District Memorial Hospital and sent the application for LTC to the home on September 2, 2016,

and they did not receive written acceptance or refusal within five business days. They further reported that CCAC did not receive a written notice or rejection letter from the home until October 2016, when they received an electronically processed denial response, 30 days after the initial request was sent. [s. 162. (3)]

Issued on this 14th day of August, 2017

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

Original report signed by the inspector.