Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

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 public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 4, 2019	2019_633577_0031	018151-19, 018152-19, 018153-19, 018154-19, 018155-19, 018156-19	Follow up

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), MELISSA HAMILTON (693)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 28, 29 and 30, 2019.

The following intakes were inspected upon during this Follow Up inspection:
-one log related to CO #001 from inspection #2019_633577_0018, issued pursuant to LTCHA, 2007 S. O 2007, c. 8, s. 19. (1);
-one log related to CO #002 from inspection #2019_633577_0018, issued pursuant to LTCHA, 2007 S. O 2007, c. 8, s. 23. (1);
-one log related to CO #003 from inspection #2019_633577_0018, issued pursuant to LTCHA, 2007 S. O 2007, c. 8, s. 24. (1);
-one log related to CO #004 from inspection #2019_633577_0018, issued pursuant to LTCHA, 2007 S. O 2007, c. 8, s. 76. (2);
-one log related to CO#005 from inspection #2019_633577_0018, issued pursuant to O.Reg 79/10, r. 212. (4) ; and
-one log related to CO #006 from inspection #2019_633577_0018, issued pursuant to O.Reg 79/10, r. 98.

A Critical Incident System (CIS) inspection #2019_633577_0030 was conducted concurrently with this follow up inspection.

During the course of the inspection, the inspector(s) spoke with two Nurse Managers, Executive Assistant and Nurse Educator.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_633577_0018	577
O.Reg 79/10 s. 212. (4)	CO #005	2019_633577_0018	577
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #002	2019_633577_0018	577
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #003	2019_633577_0018	577
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #004	2019_633577_0018	577
O.Reg 79/10 s. 98.	CO #006	2019_633577_0018	577

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 LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that they complied with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

1) The licensee was to be compliant with Compliance Order (CO) #001 from Inspection #2019_633577_0018 that was issued to the home on August 29, 2019, which had a compliance due date of September 26, 2019.

The licensee was ordered to ensure that they were compliant with section 19. (1) of the Ontario Regulation 79/10. Specifically the licensee was ordered to:

a) Ensure all residents were protected from abuse and neglect.

b) Review and revise all policies related to resident abuse and neglect to have ensured that they are in compliance with the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

c) Train all staff working on, or having responsibility for, the long-term care unit on the revised abuse and neglect policies, specifically related to abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

d) Maintain records of training.

e) Immediately report to the Director all incidents of alleged, suspected or witnessed abuse.

f) Develop and implement a system to monitor compliance with the home's abuse and neglect policies.

g) Notify the resident's SDM immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that had resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being; and notify the SDM within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

While the licensee complied with sections "a, b, e and g" of the compliance order, non-compliance continued to be identified with section "c, d and f, where the licensee was ordered to train all staff working on, or having responsibility for, the long-term care unit on the revised abuse and neglect policies, specifically related to abuse prevention, recognition, response, and reporting requirements; maintain records of the training, and develop and implement a system to monitor compliance with the home's abuse and neglect policies.

2) The licensee was to be compliant with Compliance Order (CO) #003 from Inspection #2019_633577_0018 that was issued to the home on August 29, 2019, which had a compliance due date of September 26, 2019.

The licensee was ordered to ensure that they were compliant with section 24. (1) of the Ontario Regulation 79/10. Specifically the licensee was ordered to:

a) Ensure all staff were trained to identify and report all alleged, suspected and witnessed incidents of abuse and neglect were immediately to the Director.

b) Ensure staff were familiar with and understand how to use the Licensee Reporting of Emotional Abuse Decision Tree, the Licensee Reporting of Financial Abuse Decision Tree, the Licensee Reporting of Physical Abuse Decision Tree, the Licensee Reporting of Sexual Abuse Decision Tree, the Licensee Reporting of Verbal Abuse Decision Tree and the Licensee Reporting of Neglect Decision Tree.

c) Maintain records of the training provided.

e) Develop and implement a monitoring system to ensure that abuse and neglect was reported as required by this section.

Non-compliance continued to be identified with sections “a-e”, where the licensee was ordered to train all staff to identify and report all alleged, suspected and witnessed incidents of abuse and neglect immediately to the Director; ensure staff were familiar with and understand how to use the Licensee Reporting of Abuse Decision Trees; maintain records of the training, and develop and implement a system to ensure that abuse and neglect is reported as required by this section.

Inspector #577 reviewed a memo titled, “Zero Tolerance of Abuse and Neglect of

Residents Program", dated September 19, 2019. The memo was from the Administrator, addressed to all department heads. It indicated that all staff had received an email that morning with attachments that were policies and procedures of the Zero Tolerance of Abuse and Neglect of Residents Program. The reading was mandatory and must have been signed off or an email confirmation sent to the administration office by September 24, 2019.

Inspector #577 conducted a record review of a document titled, "Zero Tolerance of Abuse and Neglect Prevention Program", which contained a list of all staff with a corresponding signature and/or email. The document did not contain dates of training and indicated that 12 staff had not signed or confirmed by email, by September 26, 2019. The top left hand corner indicated, "October 17-78%".

During an interview with Inspector #577, Nurse Manager #102, Nurse Manager #103, and Executive Assistant #014, reviewed the Compliance Orders, the home's training records and supplemental documentation. They confirmed that the home's training records did not identify dates; 12 staff had not been trained; and the home had not developed or implemented a system to monitor compliance with the home's abuse and neglect policies nor a monitoring system to ensure that abuse and neglect was reported as required. [s. 101. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 5th day of November, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577), MELISSA HAMILTON (693)
Inspection No. / No de l'inspection :	2019_633577_0031
Log No. / No de registre :	018151-19, 018152-19, 018153-19, 018154-19, 018155-19, 018156-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 4, 2019
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 Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Order / Ordre :

The licensee must be in compliance with s. 101. (3) of LTCHA, 2007 S. O 2007. Specifically the licensee must:

a) Ensure that all staff working on, or having responsibility for, the long-term care unit have been trained on the revised abuse and neglect policies, specifically related to abuse prevention, recognition, response, reporting requirements and abuse decision trees.

b) Maintain records of training, including who attended the training, and when it occurred.

c) Conduct random audits of long-term care staff, to test their knowledge to ensure they've read and understood the home's Abuse and Neglect policy.

d) Develop a checklist for Critical Incident Reporting and Mandatory reporting related to abuse and neglect, to include all aspects of s.24 (1) immediate investigation, r. 97 SDM notification, s. 24 immediate report to the Director, r. 98 police notification, r. 104 description of the incident, people involved, and actions taken.

Grounds / Motifs :

1. The licensee has failed to ensure that they complied with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

1) The licensee was to be compliant with Compliance Order (CO) #001 from Inspection #2019_633577_0018 that was issued to the home on August 29, 2019, which had a compliance due date of September 26, 2019.

The licensee was ordered to ensure that they were compliant with section 19. (1) of the Ontario Regulation 79/10. Specifically the licensee was ordered to:

a) Ensure all residents were protected from abuse and neglect.

b) Review and revise all policies related to resident abuse and neglect to ensure that they were in compliance with the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

c) Train all staff working on, or having responsibility for, the long-term care unit on the revised abuse and neglect policies, specifically related to abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

d) Maintain records of training.

e) Immediately report to the Director all incidents of alleged, suspected or witnessed abuse.

f) Develop and implement a system to monitor compliance with the home's abuse and neglect policies.

g) Notify the resident's SDM immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that had resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being; and notify the SDM within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

While the licensee complied with sections "a, b, e and g" of the compliance order, non-compliance continued to be identified with section "c, d and f, where

the licensee was ordered to train all staff working on, or having responsibility for, the long-term care unit on the revised abuse and neglect policies, specifically related to abuse prevention, recognition, response, and reporting requirements; maintain records of the training, and develop and implement a system to monitor compliance with the home's abuse and neglect policies.

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c) Maintain records of the training provided.

e) Develop and implement a monitoring system to ensure that abuse and neglect was reported as required by this section.

Non-compliance continued to be identified with sections “a-e”, where the licensee was ordered to train all staff to identify and report all alleged, suspected and witnessed incidents of abuse and neglect immediately to the Director; ensure staff were familiar with and understand how to use the Licensee Reporting of Abuse Decision Trees; maintain records of the training, and develop and implement a system to ensure that abuse and neglect was reported as required by this section.

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During an interview with Inspector #577, Nurse Manager #102, Nurse Manager #103, and Executive Assistant #104, reviewed the Compliance Orders, the home's training records and supplemental documentation. They confirmed that the home's training records did not identify dates; 12 staff had not been trained; and the home had not developed or implemented a system to monitor compliance with the home's abuse and neglect policies nor a monitoring system to ensure that abuse and neglect was reported as required. (577)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 02, 2019

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 Health and 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:

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 Health and 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 de la Santé et 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 de la Santé et 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 4th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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