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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 26, 2021	2021_829757_0010	003019-21, 003953-21	Critical Incident System

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

DAVID SCHAEFER (757)

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): April 12-16, 2021.

The following intakes were inspected during this critical incident system inspection:
-an intake related to an incident of neglect.
-an intake related to a complaint intake, which was inspected during concurrent inspection #2021_829757_0009.

This inspection was conducted concurrently with complaint inspection #2021_829757_0009 and follow-up inspection #2021_829757_0011.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Infection Prevention and Control (IPAC) Lead, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a housekeeper, and residents.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed.

Over two days, a resident did not receive their required care. The resident's care plan at the time of the incident indicated that the resident was independent with various areas of care; however, the resident had been experiencing a decline in their ability to perform care independently in the months leading up to the incident. Interviews with staff identified that they were aware that the resident was no longer able to be independent with these areas of care, but had not updated the resident's care plan to reflect this.

Sources: Resident's progress notes and care plans; the home's critical incident system (CIS) investigation file; interviews with the Director of Care (DOC) and other relevant staff members. [s. 6. (10) (b)]

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 residents are assessed and the plan of care is reviewed and revised when a resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 policy to promote zero tolerance of abuse and neglect of residents was complied with, with respect to neglect of a resident.

Ontario Regulation (O. Reg.) 79/10, s. 5, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. The home's zero tolerance of abuse and neglect of residents policy stated that it was the expectation of the home that employees protected residents from neglect.

A resident was not independent with care and required a regular care schedule to meet their needs. Over a period of two days, the resident was left unattended for a period of hours without receiving their scheduled care. Five staff members were responsible for the resident over these days, but did not provide care to the resident over these hours.

Sources: Policy "Zero Tolerance of Abuse and Neglect of Residents"; the home's CIS investigation file; the resident 's progress notes and care plan; interviews with the DOC 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 staff comply with the home's zero tolerance of abuse and neglect of residents policy, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that anyone who had reasonable grounds to suspect that neglect of a resident by staff which resulted in a risk of harm to a resident was immediately reported.

An incident of neglect occurred over a period of two days for which the home had reasonable grounds to suspect over those days. A report containing the suspicion and the information upon which it was based was not submitted to the Director until the day following the second day of neglect.

Sources: CIS report; interview with the DOC. [s. 24. (1) 2.]

Issued on this 28th day of April, 2021

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

Original report signed by the inspector.