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_0009	003599-21	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

DAVID SCHAEFER (757)

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): April 12-16, 2021.

The following intake was inspected during this complaint inspection:
-a complaint related to concerns regarding the oral care of a resident.

This inspection was conducted concurrently with critical incident system inspection #2021_829757_0010 and follow-up inspection #2021_829757_0011.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dental Hygienist (DH), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, and residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that two resident's substitute decision-makers (SDMs) were given an opportunity to participate fully in the development and implementation of the resident's plans of care.

A) A Registered Practical Nurse (RPN) identified concerns with a resident's oral health. The RPN had not contacted the resident's SDM regarding a referral to the Dental Hygienist (DH) or the oral health concerns at that time. Months later, the RPN again assessed the resident and identified their poor oral health. Following this assessment, the RPN contacted the SDM and identified the concerns and discussed a referral to the DH. The SDM identified that they would have wanted to be informed of the state of the resident's oral health condition much earlier in order to be involved in the development and implementation of a plan of care related to the resident's oral health.

B) An assessment was completed for another resident following a referral related to safety concerns. The resident's SDM was not contacted prior to the referral to inform them of the concerns or to discuss the referral related to the assessment. An intervention to manage the risk of the concern had already been implemented in the resident's care plan at the time of the assessment, and no further assessment was required at that time. The SDM indicated that they were unhappy that they were not contacted prior to the referral.

The Director of Care (DOC) indicated that both resident's SDMs should have been contacted earlier to discuss the care concerns, referrals for further assessment, and to provide an opportunity to participate in the development and implementation of their plans of care.

Sources: Two resident's progress notes and care plans; interviews with SDMs, the DOC, an RPN, and other relevant staff members. [s. 6. (5)]

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 SDMs for residents are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident received oral care to maintain the integrity of their oral tissue that included mouth care in the morning and evening.

The home referred a resident to the DH due to concerns with their oral health. The DH stated that the condition of the resident's oral health had deteriorated to a challenging condition and was consistent with someone who had not received consistent or adequate oral care. The resident's health records identified that they had not consistently received twice daily oral care in the months leading up to the referral to the DH.

The above finding is further evidence to support the compliance order related to s. 34 (1) (a), issued on February 11, 2021, during critical incident system (CIS) inspection #2021_829757_0002, to be complied April 30, 2021.

Sources: A resident's progress notes and point of care oral care records; CIS report; interviews with the DH, DOC, and other relevant staff members. [s. 34. (1) (a)]

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.