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
Oct 28, 2021	2021_914196_0004	014439-21	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

LAUREN TENHUNEN (196)

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): September 27, 28, and 29, 2021, and offsite on October 1, 2021.

The following intake was inspected upon during this Critical Incident System (CIS) inspection:
-one intake for a resident fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Nurse Manager (NM), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, Infection Prevention and Control (IPAC) practices, observed staff to resident interactions, reviewed relevant resident health care records, and policies and procedures.

This CIS inspection was conducted concurrently with Follow Up inspection #2021_914196_0003.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

The health care records indicated that resident #001 was a risk for falls and a fall prevention device was used for safety.

Resident #001 was observed seated in their chair and a fall prevention device was not in place. On the following date, a fall prevention device was in place on the resident's chair but was not operational.

Personal Support Worker (PSW) #106 acknowledged that resident #001 did not have a fall prevention device in place when observed and reported that the resident may have removed it. On the following date, PSW #106 demonstrated the resident's fall prevention device and confirmed the incorrect placement which resulted in the device not being activated.

The Nurse Manager (NM) reported that the purpose of the fall prevention device was so the staff could respond to the resident before they were to fall.

Resident #001's safety was jeopardized by not having the fall prevention device, in place and operational.

Sources: Observations of resident #001 on two dates; review of resident #001's care plan and home's policy titled, "Falls Prevention and Management - NUR 101" last reviewed June 3, 2021; and interviews with PSW #106 and the NM. [s. 6. (7)]

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 that ensures the care set out in resident #001's plan of care is provided as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #001 had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #001 had a fall with injury that required transfer to hospital and treatment.

The health care records for resident #001 indicated that a post-fall assessment tool for this fall with injury was not located.

Registered Practical Nurse (RPN) #105 reported that when a resident had a fall, a post-fall assessment tool was to be completed.

The NM confirmed that a post-fall assessment tool was not completed after this fall and it should have been done.

Sources: Review of resident #001's health care records; home's policy,"Falls Prevention and Management - NUR 101" last reviewed June 3, 2021 and CIS report; and interviews with RPN #105 and the NM. [s. 49. (2)]

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Issued on this 2nd day of November, 2021

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

Original report signed by the inspector.