Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

Original Public Report

Report Issue Date August 31, 2022
Inspection Number #2022_1283_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Nipigon District Memorial Hospital

Long-Term Care Home and City
Nipigon District Memorial Hospital, Nipigon

Lead Inspector
Christopher Amonson (721027)

Additional Inspector(s)
Lauren Tenhunen (196)

Inspector Digital Signature
Christopher E Amonson
Digitally signed by Christopher E Amonson
Date: 2022.08.31 14:54:02 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 25 - 29, 2022

The following intake(s) were inspected:

- One intake related to an allegation of resident neglect;
- One intake related to an allegation of resident-to-resident abuse;
- Two intakes related to falls with injuries.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: FALL PREVENTION AND MANAGEMENT

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 49 (2)

The licensee has failed to ensure that when a resident had fallen, staff conducted a clinically appropriate assessment.

Rationale and Summary
A resident had a fall and was found by a PSW. The Chief Nursing Executive (CNE) confirmed after reviewing the resident's health records, that no assessment was done for the resident after the fall.

There was a low level of risk to the resident with no assessment being completed which may have impeded staff's ability to reduce or mitigate falls in the future.

Sources: Critical incident report; internal investigation file; resident health records; Hospital/LTC policy titled Falls Management and Prevention LTC 7-01 (revised Jan 7, 2021); and interviews with CNE, other staff and a resident.
[#721027]

WRITTEN NOTIFICATION: FALL PREVENTION AND MANAGEMENT

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that a resident was provided with the proper implementation of an intervention specified in their care plan.

Rationale and Summary
A resident had a fall and was found by a PSW. After being assessed by an RPN it was determined the resident sustained an injury.

According to staff, investigation notes and CI report, an intervention from the resident's care plan was not implemented which may have contributed to the fall. The care plan indicated that the resident was to have this intervention in place.

There was a moderate level of risk and impact to the resident as interventions in the resident's care plan were not implemented, which may have contributed to the incident.

Sources: Critical Incident report; internal investigation notes; resident health records; Hospital/LTC policy titled Falls Management and Prevention LTC 7-01 (revised Jan 7, 2021); and interviews with CNE other staff and a resident.
[#721027]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24 (1)1.

The licensee has failed to ensure that the improper or incompetent treatment or care of a resident by staff that resulted in a risk of harm to the resident was reported immediately to the Director.

Rationale and Summary
A resident was left in alone in a vulnerable position. The plan of care indicated the resident required assistance. The CNE confirmed the incident was not reported immediately, as was required.

There was minimal risk to the resident with the delay in reporting for the incident, with no documented impact to the resident because of the delay in reporting.

Sources: Resident health records; Critical Incident report; homes' internal investigation file; the homes' policy titled: "LTC Mandatory Reporting Requirements - ADM 200-05 - last revised February 16, 2022"; and interviews with the CNE and other staff.
[#196]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 24 (1)2.

The licensee has failed to ensure that an allegation of abuse towards a resident was immediately reported to the Director.

Rationale and Summary
An alleged incident occurred between two residents. The CNE indicated the incident was not reported immediately, as was required. Staff did not immediately report the incident and they had not been trained/retrained in the long-term care home's policy to make mandatory reports.

There was minimal risk to the resident as both residents were immediately separated from each other by staff when the incident occurred with no lasting impact.

Sources: Resident health records; Critical Incident report; homes' policy titled: "LTC Mandatory Reporting Requirements - ADM 200-05 - last revised February 16, 2022"; and interviews with the CNE and other staff.
[#196]

COMPLIANCE ORDER: CO#001 DUTY TO PROTECT

NC#05 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 19 (1)

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The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with: LTCHA, 2007, s. 19 (1)

The Licensee shall:

a) Educate all direct care staff on resident safety, specifically to ensure residents who require assistance are not left unattended during specific times.

b) Ensure that the content of the education, and a record of the attendees, shall be kept and available to the inspector.

Grounds

Non-compliance with: LTCHA, 2007, s. 19 (1)

The licensee has failed to ensure that a resident was protected from neglect by staff.
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.

Rationale and Summary
A resident was left in alone in a vulnerable position. The plan of care indicated the resident required assistance.

The homes' investigation indicated the resident was left unattended and was found by staff in a vulnerable position. The CNE reported that the resident was not safe to be left unattended; was neglected; and the homes' policy on abuse and neglect was not complied with.

There was a significant level of risk to the resident as they were left alone which may have led to substantial harm to the resident.

Sources: Resident health records; Critical Incident report; homes' internal investigation file; the homes' policy titled: "Zero Tolerance of abuse and Neglect of Residents - LTC 20-01 - last revised Nov. 2021"; and interviews with the CNE and other staff.
[#196]

This order must be complied with by September 29, 2022

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.