Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Public Report

Report Issue Date: May 7, 2025
Inspection Number: 2025-1283-0003
Inspection Type: Proactive Compliance Inspection
Licensee: Nipigon District Memorial Hospital
Long Term Care Home and City: Nipigon District Memorial Hospital, Nipigon

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 7-11, 14-15, 2025
The inspection occurred offsite on the following date(s): April 14, 16, 2025
The following intake(s) were inspected:

- Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee failed to ensure care was provided to a resident as specified in their plan of care.

The current care plan for a resident identified interventions to be implemented.

The identified resident was observed without the implementation of the identified interventions.

Sources: An identified resident's health care records; and interviews with staff and the Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Plan of Care Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure the provision of care, as per the plan of care for a

resident, was documented.

An identified resident was ordered to have a treatment provided, and documentation to indicate it was completed was not recorded for several days.

Sources: Review of a resident's health care records; and interviews with the ADOC.

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)
Resident and Family/Caregiver Experience Survey
s. 43 (1) Every licensee of a long-term care home shall ensure that, unless otherwise directed by the Minister, at least once in every year a survey is taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

The licensee failed to ensure that at least once in every year a survey is taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

Sources: Resident' Council Meeting Minutes; Residents' Council Survey Questions; Workplan Quality Improvement Plan (QIP) 2024/2025; Interview with residents and Chief Nursing Executive (CNE).

WRITTEN NOTIFICATION: Emergency plans

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 90 (1)
Emergency plans

s. 90 (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including,
(a) measures for dealing with, responding to and preparing for emergencies, including, without being limited to, epidemics and pandemics; and
(b) procedures for evacuating and relocating the residents, and evacuating staff and others in case of an emergency.

The licensee failed to ensure that there were required emergency plans in place for the home that comply with the regulations.

Specifically, emergencies plans for dealing with and responding to emergencies including evacuation plans within the home were being developed and revised at the time of the inspection.

Sources: Review of email communication from the home's Chief Operating Officer (COO), Administrator, Facilities Manager; and review of emergency code plan documentation.

WRITTEN NOTIFICATION: Skin and Wound Care Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee failed to ensure the skin and wound care program was evaluated and updated annually.

Sources: Review of home's policy titled, LTC 6-04 Skin and Wound Care program; and interviews with the DOC and ADOC.

WRITTEN NOTIFICATION: Staffing Plan

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (2)
Nursing and personal support services
s. 35 (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b).

The licensee failed to ensure that there was a written staffing plan for the nursing services and personal support services programs.

Sources: Review of the home's staffing model; and an interview with the NM.

WRITTEN NOTIFICATION: Skin and Wound Care Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that two residents who exhibited skin breakdown

were reassessed at least weekly as required.

Sources: Review of two identified resident's health care records; and an interview with the ADOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee failed to ensure a resident was assessed by a Registered Dietitian (RD) when they required an assessment.

The ADOC was unable to locate a referral for the RD when the resident's care needs identified that a referral and assessment was required.

Sources: Review of a resident's health care records; and an interview with the ADOC.

WRITTEN NOTIFICATION: Pain Program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that an identified resident was assessed using a clinical appropriate assessment when the resident's pain was not relieved by initial interventions.

Sources: Review of an identified resident's health care records; and an interview with the ADOC.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee failed to ensure that the nutritional programs included the development and implementation of policies and procedures relating to nutritional care.

Pursuant to O. Reg. 246/22 r. 11 (1) (b), the licensee was to ensure that written policies and procedures for monitoring food temperatures, including at point of service, and the licensee was required to ensure the policies and procedures were

complied with.

A meal time observation identified all residents in the dining area were served food without the temperature taken prior to point of service. Review of the daily food temperature log indicated that temperatures were not taken prior to point of service during an identified period of time.

Sources: Inspector observations; LTCH Meal service temperature records; LTCH Policy titled "Food Temperatures - Point of Service"; interviews with residents, staff and Dietary Lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to implement additional requirement 10.4 (d) of the *Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes*, last revised September 2023, issued by the Director with respect to infection prevention and control.

A review of the home's monthly hand hygiene audits of staff and an interview with the home's Infection Prevention and Control Lead (IPAC) Lead, confirmed that hand hygiene audits of staff for an identified period of time were not completed as required.

Sources: Review of monthly audits of hand hygiene in the home; Review of the home's audit binder; Review of an email from the Administrator; and an Interview with the IPAC Lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

The licensee had failed to ensure that the infection prevention and control lead designated under this section worked regularly in that position on site at the home for at least 17.5 hours per week.

Sources: An interview with the IPAC lead.

WRITTEN NOTIFICATION: Evaluation

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (b)
Evaluation
s. 106. Every licensee of a long-term care home shall ensure,
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero

tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

The licensee had failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents. The policy in effect at the time of inspection had not been reviewed annually as required.

Sources: Review of the home's policy for Zero Tolerance of Abuse and Neglect of Residents (LTC 7-01); and an email from the Administrator.

WRITTEN NOTIFICATION: Medication Management System

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee failed to ensure that written policies and protocols were developed for the medication management system to ensure the appropriate administration of drugs in a long-term care home by PSWs.

A copy of the home's policy related to administration of drugs by PSWs was requested, but the home acknowledged they did not have a policy specific to PSWs at the time.

Sources: LTCH Staff Training Records; untitled draft LTCH Policy, re: PSW

medication administration; LTCH policy titled "Working with Unregulated Care Providers (PSW's)"; interviews with staff, ADOC and DOC.

WRITTEN NOTIFICATION: Drug Regimes

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (c)
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 246/22, s. 146; O. Reg. 66/23, s. 29.

The licensee failed to ensure there was a quarterly documented reassessment of a two identified resident's drug regimes.

Two resident's did not have a current quarterly medication review documented in their health care records at the time of the inspection.

Sources: Review of two identified resident's health care records, pharmacy service provider policy for Pharmacist Medication reviews and homes' Pain Management policy NUR-98; and interviews with a Registered Practical Nurse (RPN), and the ADOC.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2)
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:

1. The name and position of the designated lead for the continuous quality improvement initiative.
2. A written description of the home's priority areas for quality improvement, objectives, policies, procedures and protocols for the continuous quality improvement initiative for the next fiscal year.
3. A written description of the process used to identify the home's priority areas for quality improvement for the next fiscal year and how the home's priority areas for quality improvement for the next fiscal year are based on the recommendations of the home's continuous quality improvement committee.
4. A written description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement in the next fiscal year.
5. A written record of,
i. the date the survey required under section 43 of the Act was taken during the fiscal year,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,

iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure that a report required under O. Reg. 246/22 r. 168 (1) contained all of the information required under subsection (2).

A copy of the home's continuous quality improvement initiative report was requested, but the documentation provided by the home did not fulfill all of the requirements under O. Reg. 246/22 r. 168 (2).

Sources: Residents' Council Meeting Minutes; Residents' Council Survey Questions; Workplan Quality Improvement Plan (QIP) 2024/2025; Interview with residents and Chief Nurse Executive (CNE).

WRITTEN NOTIFICATION: CMOH and MOH

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home. Specifically, *Recommendations for Outbreak Prevention and Control in Institutions and Congregate*

Living Settings.

A. Expired Alcohol Based Hand Rub (ABHR) was observed to be in use within the home.

B. Infection Prevention and Control (IPAC) self-assessment audits were not completed or reviewed weekly as required during an outbreak.

Sources: Review of the home's completed self-assessment audits; Observations of expired ABHR; and an interview with the home's IPAC lead.

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