Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2012_104196_0023
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Aug 7, 9, 10, Sep 24, 25, Oct 9, 15, 16, 18, 21, 22, 2012
Licensee / Titulaire de permis :	NIPIGON DISTRICT MEMORIAL HOSPITAL 125 HOGAN ROAD, NIPIGON, ON, P0T-2J0
LTC Home / Foyer de SLD :	NIPIGON DISTRICT MEMORIAL HOSPITAL 125 HOGAN ROAD, P O BOX 37, NIPIGON, ON, P0T-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mr. Carl White

To NIPIGON DISTRICT MEMORIAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that all residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary; LTCHA 2007, S.O.2007,c. 8, s. 6 (10)(b).

Grounds / Motifs :

1. A Critical Incident was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in February 2012 for an incident that occurred in February 2012, in which resident #001 removed the seat belt in their wheelchair, fell and sustained a serious injury resulting in transfer to hospital. An interview was conducted with staff member #100 on August 9, 2012 and it was reported that prior to this fall in February 2012, the resident had a front closing seat belt which the resident could remove and there was also a wheelchair alarm in place. The RAI-MDS dated January 13, 2012 identified the resident as having a daily trunk restraint and the care conference notes recorded on January 12, 2012 identified that the resident is "restrained in wheelchair with lap belt to prevent resident from standing on own". The Critical Incident report and staff member #100 both identified that the resident could remove the seat belt in their wheel chair independently and as such it did not restrain the resident. The Inspector could not identify any changes to the plan of care beyond January 2012, which indicated any other assessment was done to prevent the resident from falling out of their wheelchair given they could remove their seatbelt. The licensee did not reassess the resident or review the plan of care when the resident's care needs changed and the seat belt was ineffective in preventing the resident from standing on their own. (196)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2012

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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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 to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch nité
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch mité
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of October, 2012

Signature of Inspector / Signature de l'inspecteur : Lauren Tenhunen

Name of Inspector / Nom de l'inspecteur : Lauren Tenhunen

Service Area Office / Bureau régional de services : Sudbury Service Area Office

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 7, 9, 10, Sep 24, 25, Oct 9, 15, 16, 18, 21, 22, 2012	2012_104196_0023	Critical Incident

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 inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents

During the course of the inspection, the inspector(s) conducted a tour of all resident home areas, observed the provision of care and services to residents, reviewed the home's policies and procedures for restraint use and fall prevention program, reviewed the health care records for several residents, reviewed the Critical Incident reports submitted to the Ministry of Health and Long-Term Care (MOHLTC)

Ministry of Health and Long-Term Care (MOHLTC) Log#'s: S-000065-12,S-000274-12,S-000964-12

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'Inspection prévue le Loi de 2007 les foyers de soins de longue

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. A Critical Incident was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in February 2012 for an incident that occurred in February 2012, in which resident #001 removed the seat belt in their wheelchair, fell and sustained a serious injury resulting in transfer to hospital. An interview was conducted with staff member #S100 and it was reported that prior to this fall in February 2012, the resident had a front closing seat belt which the resident could remove and there was also a wheelchair alarm in place. The RAI-MDS dated January 13, 2012 identified the resident as having a daily trunk restraint and the care conference notes recorded on January 12, 2012 identified that the resident is "restrained in wheelchair with lap belt to prevent resident from standing on own". The Critical Incident report and staff member #100 both identified that the resident could remove the seat belt in their wheel chair independently and as such it did not restrain the resident. The Inspector could not identify any changes to the plan of care beyond January 2012, which indicated any other assessment was done to prevent the resident from falling out of their wheelchair, given they could remove their seat belt. The licensee did not reassess the resident or review the plan of care when the resident's care needs changed and the seat belt was ineffective in preventing the resident from standing on their own.

The licensee failed to 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, (b) the resident's care needs change or care set out in the plan is no longer necessary; [LTCHA 2007, S.O. 2007,c. 8, s. 6 (10)(b).]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.

Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,

(a) use of physical devices;

(b) duties and responsibilities of staff, including,

(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,

(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device;

(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;

(d) types of physical devices permitted to be used;

(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented;

(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and

(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The inspector reviewed the home's written policy # SAF-1-08 titled "Restraints" with a revision date of June 2008. The policy did not deal with the types of physical devices permitted to be used in the home.

The licensee failed to ensure that the home's written policy under section 29 of the Act deals with, (d) types of physical devices permitted to be used; [O.Reg.79/10,s.109.(d)]

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 will ensure the home's written policy under section 29 of the Act deals with the types of physical devices permitted to be used, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.

2. Mental health issues, including caring for persons with dementia.

3. Behaviour management.

4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.

5. Palliative care.

6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. A Critical Incident was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in February 2012 for an incident that had occurred in February 2012, in which resident #001 removed the lap seat belt in their wheelchair, fell and sustained a serious injury requiring transfer to hospital. The RAI-MDS dated January 13, 2012 identified the resident as having a daily trunk restraint and the plan of care noted the resident at "high" risk for falls. There was a physician's order dated December 30, 2011 for "Restrain in wheelchair with lapbelt prn". The care conference notes recorded on January 12, 2012 identified that the resident is "restrained in wheelchair with lap belt to prevent resident from standing on own". On August 9, 2012, staff member #S101 was interviewed and told the inspector that a lap belt is a restraint. An interview was conducted with staff member #S100 to determine if the lap belt used on resident #001 was considered a restraint or not as the resident was known to remove the belt on their own. Staff member #S100 stated "when a seat belt was used they thought it was a restraint", "now knows that if a resident is able to remove it, it is not a restraint". These two direct care staff members did not have an understanding of restraints as is set out in the Act and Regulations.

The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. [LTCHA 2007,S.O.2007,c.8,s.76.(7)4.]

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 that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations, to be implemented voluntarily.

Issued on this 23rd day of October, 2012

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