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
Sep 2, 2020	2020_752627_0012	011764-20, 014803-20, 014806-20, 014807-20, 014986-20	Complaint

Licensee/Titulaire de permis

1895357 Ontario Inc.
1202 Highway 94 Corbeil ON P0H 1K0

Long-Term Care Home/Foyer de soins de longue durée

Nipissing Manor Nursing Care Center
1202 Highway 94 Corbeil ON P0H 1K0

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

SYLVIE BYRNES (627), LOVIRIZA CALUZA (687)

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): July 20-25, 28-31, and August 4-7, 2020.

The following intakes were inspected during this complaint inspection;

- One intake related to verbal abuse of a resident by staff and feeding assistance for residents;
- Three intakes related to staffing shortages and possible neglect of residents; and,
- One intake related to staffing shortages on weekends.

A follow-up inspection, #2020_752627_0013, was conducted concurrently with this complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dietary Manager, Life Enrichment Coordinator, Executive Assistant, staff members, residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs and resident health care records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **1 VPC(s)**
- **6 CO(s)**
- **1 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).

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

Inspector #687 reviewed a falls report which indicated that a resident had an unwitnessed fall. The resident sustained minor injuries. The resident was not wearing any shoes or socks at the time of the fall.

In a review of a second fall report, Inspector #687 identified that the resident had a witnessed fall. The resident was not wearing any shoes at the time of the fall.

Inspector #687 reviewed the home's policy "The Care Plan" which indicated that, "The purpose of the Care Plan was to provide a guide of supervision and by using the plan, it could be determined if the resident had received the necessary care".

Inspector #687 reviewed the resident care plan for the focus of falls which identified that staff was to ensure that the resident had non-skid socks at all time, and shoes when they were up.

Inspector #687 interviewed a staff member who stated that the resident had a witnessed fall when they were not wearing their shoes or socks.

Inspector #687 interviewed another staff member who stated that the resident had an unwitnessed fall which caused minor injuries. The staff member stated that the resident

was not wearing their shoes or socks, at the time of the fall.

Inspector #687 interviewed the Director of Care (DOC) who acknowledged that the resident had multiple witnessed and unwitnessed falls. The DOC stated that the resident's falls prevention interventions included non-slip footwear and socks. The DOC further stated that the staff were to follow the resident's fall interventions as stated in the resident's plan of care and to ensure that the interventions were put in place.

2. A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

a) Inspector #687 observed a resident in their bedroom, on two separate occasions. The resident's call bell was not within reach of the resident.

Inspector #687 reviewed the home's policy "The Care Plan", which indicated that "The purpose of the Care Plan was to provide a guide of supervision and by using the plan, it can be determined if the resident had received the necessary care".

Inspector #687 reviewed the resident's care plan and identified for the focus of falls that the staff was to ensure that the resident's call bell was within easy reach.

Inspector #687 interviewed the resident who stated that they knew how to call for assistance; however, they were not sure where their call bell was.

Inspector #687 interviewed a staff member who indicated that the resident's call bell was supposed to be within easy access, but it was not at this time.

Inspector #687 interviewed another staff member who indicated that the resident was at risk for falls. The staff member further stated that the resident's fall prevention intervention included that their call bell be within easy reach. The staff member verified that the resident's call bell was not accessible to the resident at that time.

Inspector #684 interviewed the DOC who stated that call bells were required to be within easy access for all residents in the home. The DOC acknowledged that the staff had to ensure that the resident's call bell was within easy reach to call for staff assistance and for their safety.

b) Inspector #687 reviewed a fall report and identified that a resident had an unwitnessed fall, which caused minor injuries. The resident was not wearing shoes at the time of the incident.

Inspector #687 reviewed the resident's care plan and identified for fall prevention interventions, the staff were to ensure that the resident was wearing appropriate footwear (shoes, non-slip slippers and non-skid socks) when they were up.

Inspector #687 interviewed a staff member who indicated that the resident had an unwitnessed fall and that they sustained minor injuries. The staff member verified that the resident was not wearing their shoes at the time of the incident. The staff member further stated that the resident's fall prevention plan included ensuring that the resident was wearing appropriate footwear such as shoes or non-slip socks.

Inspector #687 interviewed the DOC who verified that the resident had an unwitnessed fall and sustained minor injuries. The DOC further verified that the resident was not wearing non-slip footwear at the time of the incident, which was part of the resident's fall prevention interventions. The DOC stated that the staff were to follow the resident's fall interventions as stated in the resident's plan of care and to ensure that those interventions were implemented. [s. 6. (7)]

3. A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

Inspector #687 observed a resident not wearing their glasses on two separate occasions.

Inspector #687 reviewed a fall report for the resident which identified that the resident had an unwitnessed fall that caused minor injuries. The resident was not wearing their eye glasses at the time of the incident.

Inspector #687 reviewed the home's policy "The Care Plan" which indicated that "The purpose of the Care Plan was to provide a guide of supervision and by using the plan, it can be determined if the resident had received the necessary care".

Inspector #687 reviewed the resident's care plan which identified that staff was to ensure that glasses were on, labelled, clean, free of scratches & in good repair.

Inspector #687 interviewed a staff member who stated that the resident's fall prevention interventions included for staff to ensure that the resident's glasses were applied.

Inspector #687 interviewed a second staff member who stated that the resident had sustained an unwitnessed fall and that the resident was not wearing their glasses at the time of the fall.

Inspector #687 interviewed the DOC who acknowledged that the resident had an unwitnessed fall. The DOC further recognized that the resident was not wearing their glasses at the time of the fall. The DOC stated that the staff were to ensure that the resident's glasses were applied as part of the resident's falls prevention intervention. [s. 6. (7)]

4. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

Inspector #687 reviewed a Physician's order, for a resident, for a specific treatment to be provided to the resident at specific times.

Inspector #687 reviewed the resident's documentation of when the treatment was given to the resident and identified six different times when documentation had not been completed for periods of five to 10 days.

Inspector #687 reviewed the home's policy titled "Charting and Documentation" which indicated that the resident's clinical record was an account of treatment, care, response to care, signs and symptoms and progress of the resident's condition.

Inspector #687 interviewed the resident who stated that the nurses were providing them with the treatment, at the right time, as the Physician had ordered.

Inspector #687 interviewed a staff member who stated that the resident had a scheduled treatment which had been ordered by a Physician.

Inspector #687 interviewed a second staff member who stated that the resident was scheduled to receive a treatment and that the treatment was to be documented on a

specific form.

Inspector #687 interviewed another staff member who stated that residents who required this treatment, had a schedule for their treatment and that staff were to complete a specific form, after the treatment was completed.

Inspector #687 interviewed the DOC, who acknowledged that the registered staff were not documenting that they had provided the resident with the ordered treatment, for the resident. The DOC stated “I recognized that if the staff did not document it, then the staff did not do it”. [s. 6. (9) t.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident’s money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a

resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

During an interview with a staff member, they reported to Inspector #627 that they had made the Administrator aware of a physical altercation between two residents which had caused minor injuries to one of the residents, approximately two weeks ago.

Inspector #627 reviewed the home's policy titled "Zero Tolerance Policy on Abuse and Neglect", which defined physical abuse as "the use of physical force by a resident that causes a physical injury to another resident". The policy also indicated that any person who has reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or risk of harm to the resident was to immediately report that suspicion and the information upon which the suspicion was based to the Director appointed by the Minister of Health and Long-Term care.

a) Inspector #627 reviewed progress notes for both residents and identified a progress note which indicated that a resident had approached the staff member and told them that a resident had caused them an injury when the had attempted to assist them.

Inspector #627 reviewed the Nurse-Manager shift report which indicated that a resident had injured another resident during an altercation.

Inspector #627 interviewed the staff member who stated that they had reported the incident to the Administrator.

Inspector #627 interviewed another staff member who stated that if they had documented it on the shift report, they had made the DOC aware.

b) Upon further review of the resident's progress notes, Inspector #627 reviewed a progress note which indicated that a resident had injured another resident. It was identified that the charge nurse was made aware.

Inspector #627 reviewed the day's Nurse-Manager shift report which indicated that the resident was wandering and had a physical altercation with another resident.

Inspector #627 interviewed a staff member who stated that they had documented the incident on the shift report. The staff member stated that the process was to call the DOC at home, and they would decide if this was reportable. The staff member stated

they could not recall if they had called the DOC; however, they had documented the incident on the shift report.

Inspector #627 interviewed the DOC, who stated that the Nurse-Manager shift report was to be read to the oncoming staff as well as registered staff. It was also sent to all managers and read on every shift. If something was unclear, the DOC stated that they would call the home if they needed more details. The DOC stated that the process for the home, when there was an incident of resident to resident altercation was to separate the residents, treat any wounds, documented in Point Click Care, and notify the [substitute decision makers (SDMs)]. The DOC further stated that the above incidents had not been reported as in the past, the home had reported all resident altercations, and this had caused the home to be investigated as they were reporting more altercations than other homes. The DOC stated that it was tough to know when to report, and that the Administrator and themselves would decide together if they needed to report an incident.

Inspector #627 interviewed the Administrator who stated that when there was a physical altercation between two residents, they would use the "falls legislation" to determine if the altercation rose to the level of being a critical incident whereby, the resident who had been injured had a significant change to their health due to the altercation. If it did rise to this critical level, then they would report the incident. The Administrator further stated that they had not been made aware of the aforementioned altercation. [s. 24. (1)]

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Ontario regulations (O.Reg.) 79/10, of the Long-Term Care Homes Act 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 or inaction that jeopardizes the health, safety or well being of one or more residents".

During an interview with a staff member, they informed Inspector #627 that they had worked a shift and that during a meal service, they had noticed that a resident had soiled themselves. The staff member stated that they had taken the resident to their room to provide them with continence care and noticed that the appropriate continence care

interventions had not been provided. After having provided the resident with continence care, the staff member stated that they had went to verify the documentation sheet for care given and noted that another staff member had signed that they had provided continence care to the resident. The staff member stated that they had reported the incident to the charge nurse.

Inspector #627 interviewed a second staff member who stated they had made the Administrator aware of the incident the following day, during a meeting. The staff member stated that they had brought forth at least twice that the staff member was often neglectful when providing care.

Inspector #627 interviewed a staff member who stated they were not sure if they had provided continence care to the resident as per their care plan. The staff member stated that no one had spoken to them about the incident.

Inspector #627 was provided with a copy of a letter. The letter described a situation that unfolded during a shift, on a specified date. The letter described how a resident was not provided continence care as per their care plan. It was determined that the best action regarding the incident was to inform the DOC and the Administrator. The staff member stated that they had forwarded a copy of the letter to the Administrator.

Inspector #627 reviewed the resident’s care plan for toileting. The care plan directed staff to provide the resident with specific continence care interventions.

Inspector #627 interviewed the DOC who stated that the incident had not been reported to the Ministry. The DOC stated that the Administrator and themselves had a meeting with the staff member, whereby the Administrator had asked the staff member if the had provided continence care to the resident and that the staff member had denied not providing continence care to the resident as per their care.

Inspector #627 interviewed the Administrator who stated they could not recall being made aware of this incident prior to receiving the letter from the two staff members. The Administrator stated that they had met with the staff member and a union member, whereby the staff member had stated that they provided continence care to the resident as per the resident’s care plan, and that the incident was not reported to the Ministry. [s. 24. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

During interviews with Inspector #627, multiple staff members brought forth concern that the staffing levels had not permitted staff to provide care to the residents as per their care plan. A staff member stated that "last night there was only two of us, we had four baths, I gave one full tub bath, the other ones, one refused I did not ask them again, the other two we did not have time, we gave a good bed bath to two residents".

A second staff member stated that when they came in, the home seemed like it was in a "scramble" as staff were trying to complete their duties and the oncoming staff were trying to get report. The staff member stated that baths were deferred due to the lack of staffing. The staff member stated that they were not proud to say that when a bath was refused, it was not offered again and that staff "did not document things that would hurt [them]". The staff member stated that when care was not provided, they had been

directed by the Administrator to leave the “check off area blank” and that “usually we put BB for a bed bath”.

a) Inspector #627 interviewed a resident who stated that there was hardly any staff on weekends, and this affected the care they received. The resident stated that they were getting up later than they wished. As well, the resident stated that a few weeks ago, they were told that there was no time for a tub bath and that they would receive a bed bath instead.

Inspector #627 reviewed the documentation for the resident for a period of three months and noted that on one occasion, the resident had received a bed bath, and on another occasion, documentation had not been completed

A progress note indicated that on one occasion, when the resident had been going for their bath, they had been told that due to time constraint, their bath would have to be given quickly. The resident had voiced their disapproval then.

A review of the resident's care plan, for the focus of bathing indicated that staff were to allow a specific time frame when assisting the resident with their bath.

b) Inspector #627 reviewed the sign off documentation sheet indicating the care received for a second resident, for a three-month period and noticed that there was no documentation regarding bath care for three dates; the sign off area were left blank and no progress notes were written, identifying why the documentation had been left blank.

A review of the resident's care plan, for bathing, indicated that the resident was to receive a specific bath twice weekly by staff.

c) The Inspector reviewed the documentation for a third resident which indicated the care received, for a three-month period and noted that on nine occasions, the documentation was left blank and on one occasion, it was indicated that the resident had received a bed bath.

Progress notes indicated that the resident had refused their bath on two occasions.

A review of the resident’s care plan, for bathing, indicated that the resident was to receive a shower twice weekly.

d) The Inspector reviewed a progress note for a fourth resident which indicated, "[staff member] reported they where unable to complete resident's bath this afternoon due to short staffing. Charge nurse [made] aware".

e) The Inspector reviewed a progress note for a fifth resident which indicated “[staff member] reported they were unable to complete resident’s bath this afternoon due to short staffing. Charge nurse aware”.

f) Inspector reviewed progress notes for five residents, for a specific date which indicated “Resident did not receive bath this shift due to time constraint”.

Inspector #627 interviewed a staff member who stated that baths were not always completed, or a bed bath would be given when the home was short staffed. They stated that the home was always multiple staff members short, and that on a specific weekend, the home was six staff members short, which was one third of their staff.

Inspector #627 interviewed another staff member who stated that staff would report to them when baths could not be completed due to staffing shortages, and this would be added to the shift report to make the oncoming shift and management aware. The staff member further stated, "I am ashamed to say, the baths are usually not made up".

Inspector #627 interviewed the DOC who stated that when the home was short staffed and baths could not be completed due to time constraints, the staff members were to give the residents a "good" bed bath and the residents would get a bath on their next scheduled bath day. [s. 33. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

During an interview with Inspector #627, a staff member stated that they when they had left the home, on a specific day, after their shift, many residents had not received bedtime (hs) care and were still sitting in their wheelchair. The staff member stated that they recalled that seven residents were not yet in bed and had not been provided with hs care, when they had left.

Inspector #627 reviewed the evening shift report for the above shift, which indicated that seven residents, on one floor had not been provided with hs care and four residents on another floor had not been provided with hs care.

Inspector #627 reviewed a progress note, which indicated “Resident upset this evening/night because it was late and evening staff had not gotten [them] ready for bed yet. Resident had stated that this has happened multiple times now and that [they have] not been getting ready for bed at their preferred time the past few nights”.

Inspector #627 reviewed the home’s policy “The Care Plan”, which indicated that the purposes of the care plan was to “record the resident’s own preferences and approach to their care; how do they like to be addressed; do the retire early or late. To answer appropriately the question: Did we meet the needs of this resident as stated in our long- and short-term objectives”.

The Inspector reviewed the care plans in effect at the time of the incident, for the focus of preferred bed times, for the above residents and noted that the residents’ had preferred bed times.

Inspector #627 interviewed two of the above residents who stated that they were upset as they felt they were always the last one to be assisted to bed, and that at times it was past their preferred bed time, before they were assisted to bed.

The Inspector interviewed a third resident who stated that they often went to bed on their own. The resident said they would then wait for someone to come and assist them with washing and brushing their teeth.

The Inspector interviewed a forth resident who stated that they often undressed and transferred to bed on their own, although the Physician had warned them against it, as often they had not received help by the time they were ready for bed

Inspector #627 interviewed a staff member who stated that on a specific shift, when they had left, there remained seven residents who were still up and had not received hs care.

Inspector #627 interviewed another staff member who stated they had worked the night shift on a specific date. The staff member stated that when they had arrived for their shift, everyone was scrambling to finish their duties, while on coming staff got report. The staff member stated that residents remained up and had not been provided with hs care yet, as the home was short staffed for the evening shift.

Inspector #627 interviewed the DOC who stated that the residents' care plan for "desired bed time" was to let staff know when the residents wanted to go to bed, and that it should be respected. "I would hope that all residents who want to go to bed, be put to bed and the ones who are able to understand would be told that the staff would come back to provide them with care, and if they dosed off, they would be woken up but only rarely, when there [was] no other choice". [s. 41.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

Inspector #627 interviewed a staff member who stated that because of staff shortages, some residents were not toileted or provided with continence care as often as they needed to be. The staff member further stated that they had to tell residents who were able to ask to be toileted to "hang on" as the wait depended on the other residents "who were going", and that at times, the wait was much too long.

Inspector #627 interviewed a resident who stated that they were not provided with assistance right away when they required to use the toilet and that they frequently had to wait “much too long”.

a) On a specific date, Inspector #627 observed a resident in the dining room for a meal service. After the meal, the resident was assisted to the activity room, where they remained until the next meal service, when they were returned to the dining room. After the meal service, the resident was returned to bed, but was not provided with continence care.

On another day, Inspector #627 observed the resident in the dining room, for a meal service. When the meal was completed, the resident was brought to the activity room where they remained until they were transferred to bed by a staff member.

The Inspector interviewed a staff member who was caring for the resident. They stated that they had provided continence before two meal services.

On a third day, the Inspector observed the resident in the dining room for a meal service. After the meal, the resident was transferred to the activity room. The resident was brought to their room and provided continence care approximately one hour and a half later.

Inspector #627 reviewed the resident care plan and noted for urinary/bowel continence, the resident wore an incontinence product, the staff was to provide assistance as required, check for incontinence every morning, every evening, before and after meals, every nursing round during the night and as required.

Inspector #627 interviewed a staff member who stated that the resident was provided with continence care prior to getting up. The staff member further stated that the resident was usually provided with continence care once more during the day, however, they had not provided continence care to the resident when they returned them to bed as they were unable to provide the care by themselves and that afternoon shift would provide the resident with continence care.

Inspector #627 interviewed a second staff member who stated that they had not been able to provide the resident with continence care; " I did not have time to toilet [them], we do our best. I had to do the water rounds and answer call bells. I never got to toilet [them]".

Inspector #627 interviewed another staff member who stated that they had not provided the resident with continence care, as they had been changed earlier in the day.

b) On a specified date, a second resident was observed in the dining room for a meal service. After the meal service, the resident was assisted to the activity room where they remained until the next meal service, when they were transferred to the dining room. The resident had not been checked for incontinence or provided with continence care.

On a later date, Inspector #627 observed the resident in the dining room for a meal service. After the meal, the resident was assisted to the activity room, where they remained until the next meal service. The resident was not checked for incontinence or provided with continence care.

Inspector #627 reviewed the resident's care plan which directed staff to provide assistance and to toilet the resident every morning, at bedtime, before and after meals,

on every nursing round during the night and as required.

Inspector #627 interviewed a staff member who stated that the resident had been provided with continence care in the morning, and before lunch, as the resident had soiled themselves. The staff member further stated that after lunch, the staff attempted to return all residents to bed, however, there was not enough time to provide continence care to all residents and afternoon shift would be providing the care to the residents who were missed.

Inspector #627 interviewed another staff member who stated that they often missed the between breakfast and lunch continence care because there are not enough staff members.

Inspector #627 interviewed a third staff member who stated that "usually when we return the residents to bed, we provide continence care. It has been crazy, things have to change! We do not have enough time to provide the resident with continence care. We do if we smell they had a bowel movement, but we don't toilet them often enough. Things have to change".

c) On a specific date, Inspector #627 observed a resident in the dining room for a meal service. When the meal was finished, the resident was brought to the activity room where they remained for three hours, when they were returned to their room and left sitting in their chair. The resident was not provided continence care. Inspector #627 asked the resident if they felt their brief was wet, to which the resident replied "yes". Three minutes later, the resident was returned to the activity room, awaiting the next meal service. The resident had not been checked for incontinence or provided with continence care.

At a later date, Inspector #627 observed the resident in the dining room for a meal service. After the meal, the resident was assisted to the TV room. Two hours later, the resident was observed trying to leave the TV room, when a staff member assisted them back to the TV room and told the resident "[the meal] will be here soon". The resident remained in the TV room until the meal service. They were not checked or provided with continence care.

Inspector #627 reviewed the resident's care plan which directed staff to provide assistance for continence care in the morning, at bedtime, before and after meals and when required.

Inspector #627 interviewed a staff member who stated that they had gotten the resident up, however they were short staffed and hadn't had the time to bring the resident back to their room. The staff member further stated that staff would call them if they had noticed that the resident had soiled themselves or had asked to be toileted.

Inspector #627 interviewed another staff member, a short while after they had started their shift. When the Inspector inquired if the resident was provided with continence care, the staff member checked and found the resident to have a soiled continence product. They proceeded to provide the resident with continence care.

Inspector #627 interviewed the DOC who stated that the expectation was that residents would be brought to a private area or transferred to bed and would be checked for incontinence and provided with continence care if required, in the morning, before and after meals, at bedtime and when required. [s. 51. (2) (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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 a resident 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.

A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

a) Inspector #687 reviewed a resident's Head Injury Routine (HIR) specifically related to the resident's fall incidents. Please see WN #1, item #3 for further details.

For a period of approximately four months, Inspector #687 identified that a resident had eight unwitnessed fall incidents, whereby an HIR were initiated. The Inspector further identified that the staff members had partially completed the resident's HIR. The vitals signs were not completed on 19 occasions; "sleeping" was documented.

b) Inspector #687 reviewed a second resident's HIR report, specifically related to the resident's fall incidents. Please see WN #1, item #1 for details.

For a period of approximately four months, Inspector #687 identified that the resident had four unwitnessed fall incidents and HIR were initiated. The Inspector further identified that the staff members had partially completed the resident's HIR. The vital signs were not completed on nine occasions; "sleeping" was documented.

c) Inspector #687 reviewed a third resident's HIR documentation record, specifically related to the resident's fall incidents. Please see WN #1, item #2 for further details.

For a period of approximately four months, Inspector #687 identified that the resident had one witnessed and four unwitnessed fall incidents and HIR were initiated. The Inspector further identified that the staff members had partially completed the resident's HIR. The vitals signs were not completed on ten occasions; "sleeping" was documented.

Inspector #687 reviewed the home's policy "Medical Directive: Head Injury Routine", which indicated that "This directive applies to residents of Nipissing Manor Nursing Home and Retirement Home who had sustained a head injury":

Routine #1: Vital signs - every 15 minutes x 30 minutes
- every hour x 4 hours
- every 6 hours x 24 hours

Routine #2: Vital signs (Resident on any anti-coagulant therapy - Coumadin, Heparin, Fragmin, ASA) - every 15 minutes x 30 minutes

- every hour x 4 hours
- every 6 hours x 48 hours

Inspector #687 interviewed two staff members who stated that when a resident had an unwitnessed fall or had reported that they had hit their head, a HIR would be initiated. The staff member further stated that if the resident was sleeping during a scheduled Head Injury Routine neuro-vital check, “sleeping” would be documented in the HIR documentation record.

Inspector #687 interviewed the DOC who stated that when a resident had an unwitnessed fall, reported a head injury or staff witnessed a resident who sustained a head injury, a HIR routine would be initiated. The DOC stated that the registered staff were to take the residents HIR routine as outlined in the HIR Policy and that the registered staff must wake the resident up to obtain their neuro-vital signs if they were sleeping. [s. 49. (2)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

During an interview with Inspector #627, two staff members stated that the directives from management was that “when a resident presented with a fever, because we were using so many gowns, we were told to give it 24 hours, with fever, as it could be a urinary tract infection (UTI), before we isolated the resident. When it was hot and a resident presented with a fever of 37.7 to 38.4 degrees Celsius, we were told to let it go”.

Inspector #627 reviewed the progress notes for resident #007 and identified a progress note which indicated that a resident had a temperature of 38.4 degrees Celsius (C). A second progress note on the same day identified that the resident also had atypical symptoms.

Inspector #627 reviewed the home's policy, "Infection Control; Pandemic Response", which indicated that "for pandemic activity in the province or country but no pandemic activity in the community, a more active approach to surveillance was required: actively seeking out signs or symptoms in residents, normal reporting procedures to the North Bay Parry Sound District health Unit will continue. Infection prevention and control measures will be implemented: Gowns during any procedure or resident care activity where clothing may be contaminated, surgical masks for all direct care within one meter of the resident, protective eye wear when providing direct care within one meter of the resident, eye protection must provide a barrier to splashes from the side".

Inspector #627 reviewed the “Ministry of Health COVID-19 Reference Document for Symptoms “, which was provided to all nursing homes, and identified "Common symptoms of COVID-19 which included a fever (temperature of 37.8°C or greater). Atypical symptoms included, gastrointestinal symptoms (nausea, vomiting and diarrhea). The Required Precautions were listed as “Droplet and Contact precautions for the routine care of patients with suspected or confirmed COVID-19”.

Inspector #627 interviewed a staff member who stated that they had been made aware that resident #007 was febrile and had another atypical symptom. They further stated that the resident had not been on isolation precaution as they had been directed by the DOC to "just monitor them".

Inspector #627 interviewed the DOC who stated that signs and symptoms of Covid-19 were posted throughout the building and that staff were to report any symptom or when a resident was feeling "off". The DOC stated that they were made aware that the resident had a fever, however they were not told of the atypical symptom. The DOC further stated that the resident was already on contact isolation and they wanted to rule out a UTI prior to placing them on respiratory isolation. [s. 229. (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 the ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents clearly set out what constituted abuse and neglect.

Inspector #627 reviewed the home's policy "Zero Tolerance Policy on Abuse and Neglect". The policy clearly described what constituted abuse; however, there was no definition of neglect.

During an interview with Inspector #627, the DOC stated that they would have to see if there was another part of the policy that was missing, and would get back to the Inspector.

Inspector #627 interviewed the Administrator who stated that they had discussed the policy with the DOC and could not identify a definition of neglect. [s. 20. (2) (b)]

Issued on this 8th day of September, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE BYRNES (627), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2020_752627_0012
Log No. / No de registre :	011764-20, 014803-20, 014806-20, 014807-20, 014986-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 2, 2020
Licensee / Titulaire de permis :	1895357 Ontario Inc. 1202 Highway 94, Corbeil, ON, P0H-1K0
LTC Home / Foyer de SLD :	Nipissing Manor Nursing Care Center 1202 Highway 94, Corbeil, ON, P0H-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Wentworth Graham

To 1895357 Ontario Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 # / No d'ordre : 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. (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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA, 2007.

Specifically, the licensee must:

a) Ensure that the provision of the care set out in the plan of care is provided to the residents, for fall interventions.

b) Develop and conduct audits to ensure that fall prevention interventions are implemented as required. Maintain a record of the audits that are conducted. A copy of the audits shall be provided to the Inspector(s) upon request.

Grounds / Motifs :

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

A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

Inspector #687 reviewed a falls report which indicated that a resident had an unwitnessed fall. The resident sustained minor injuries. The resident was not wearing any shoes or socks at the time of the fall.

In a review of a second fall report, Inspector #687 identified that the resident had a witnessed fall. The resident was not wearing any shoes at the time of the fall.

Inspector #687 reviewed the home's policy "The Care Plan" which indicated that, "The purpose of the Care Plan was to provide a guide of supervision and by

using the plan, it could be determined if the resident had received the necessary care".

Inspector #687 reviewed the resident care plan for the focus of falls which identified that staff was to ensure that the resident had non-skid socks at all time, and shoes when they were up.

Inspector #687 interviewed a staff member who stated that the resident had a witnessed fall when they were not wearing their shoes or socks.

Inspector #687 interviewed another staff member who stated that the resident had an unwitnessed fall which caused minor injuries. The staff member stated that the resident was not wearing their shoes or socks, at the time of the fall.

Inspector #687 interviewed the Director of Care (DOC) who acknowledged that the resident had multiple witnessed and unwitnessed falls. The DOC stated that the resident's falls prevention interventions included non-slip footwear and socks. The DOC further stated that the staff were to follow the resident's fall interventions as stated in the resident's plan of care and to ensure that the interventions were put in place.
(687)

2. A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

a) Inspector #687 observed a resident in their bedroom, at two separate occasions. The resident's call bell was not within reach of the resident.

Inspector #687 reviewed the home's policy "The Care Plan", which indicated that "The purpose of the Care Plan was to provide a guide of supervision and by using the plan, it can be determined if the resident had received the necessary care".

Inspector #687 reviewed the resident's care plan and identified for the focus of falls that the staff was to ensure that the resident's call bell was within easy reach.

Inspector #687 interviewed the resident who stated that they knew how to call for assistance; however, they were not sure where their call bell was.

Inspector #687 interviewed a staff member who indicated that the resident's call bell was supposed to be within easy access, but it was not at this time.

Inspector #687 interviewed another staff member who indicated that the resident was at risk for falls. The staff member further stated that the resident's fall prevention intervention included that their call bell be within easy reach. The staff member verified that the resident's call bell was not accessible to the resident at that time.

Inspector #684 interviewed the DOC who stated that call bells were required to be within easy access for all residents in the home. The DOC acknowledged that the staff had to ensure that the resident's call bell was within easy reach to call for staff assistance and for their safety.

b) Inspector #687 reviewed a fall report and identified that a resident had an unwitnessed fall, which caused minor injuries. The resident was not wearing shoes at the time of the incident.

Inspector #687 reviewed the resident's care plan and identified for fall prevention interventions, the staff were to ensure that the resident was wearing appropriate footwear (shoes, non-slip slippers and non-skid socks) when they were up.

Inspector #687 interviewed a staff member who indicated that the resident had an unwitnessed fall and that they sustained minor injuries. The staff member verified that the resident was not wearing their shoes at the time of the incident. The staff member further stated that the resident's fall prevention plan included ensuring that the resident was wearing appropriate footwear such as shoes or non-slip socks.

Inspector #687 interviewed the DOC who verified that the resident had an unwitnessed fall and sustained minor injuries. The DOC further verified that the resident was not wearing non-slip footwear at the time of the incident, which was part of the resident's fall prevention interventions. The DOC stated that the staff

were to follow the resident's fall interventions as stated in the resident's plan of care and to ensure that those interventions were implemented. [s. 6. (7)] (687)

3. A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

Inspector #687 observed a resident not wearing their glasses on two separate occasions.

Inspector #687 reviewed a fall report for the resident which identified that the resident had an unwitnessed fall that caused minor injuries. The resident was not wearing their eye glasses at the time of the incident.

Inspector #687 reviewed the home's policy "The Care Plan" which indicated that "The purpose of the Care Plan was to provide a guide of supervision and by using the plan, it can be determined if the resident had received the necessary care".

Inspector #687 reviewed the resident's care plan which identified that staff was to ensure that glasses were on, labelled, clean, free of scratches & in good repair.

Inspector #687 interviewed a staff member who stated that the resident's fall prevention interventions included for staff to ensure that the resident's glasses were applied.

Inspector #687 interviewed a second staff member who stated that the resident had sustained an unwitnessed fall and that the resident was not wearing their glasses at the time of the fall.

Inspector #687 interviewed the DOC who acknowledged that the resident had an unwitnessed fall. The DOC further recognized that the resident was not wearing their glasses at the time of the fall. The DOC stated that the staff were to ensure that the resident's glasses were applied as part of the resident's falls prevention intervention. [s. 6. (7)]

The severity of this issue was determined to be a level two, as there was minimal harm. The scope of the issue was a level three, as three out of three residents were not provided care as per the care plan. The home had a level three compliance history with related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10:
-Voluntary Plan of Correction (VPC) issued October 26, 2017, (2017_655679_0011);
-Written Notification (WN) issued October 12, 2018, (2018_633577_0011).
(687)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must:
1. Ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director:
i) Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident;
ii) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

2) Re-educate staff and management on the requirements under s. 24 (1), for reporting certain matters to the Director.

3) Document who provided the re-education and who attended the education. The documentation will be provided to the Inspector, upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

During an interview with a staff member, they reported to Inspector #627 that they had made the Administrator aware of a physical altercation between two residents which had caused minor injuries to one of the residents, approximately two weeks ago.

Inspector #627 reviewed the home's policy titled "Zero Tolerance Policy on Abuse and Neglect", which defined physical abuse as "the use of physical force by a resident that causes a physical injury to another resident". The policy also indicated that any person who has reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or risk of harm to the resident was to immediately report that suspicion and the information upon which the suspicion was based to the Director appointed by the Minister of Health and Long-Term care.

a) Inspector #627 reviewed progress notes for both residents and identified a progress note which indicated that a resident had approached the staff member and told them that a resident had caused them an injury when the had attempted to assist them.

Inspector #627 reviewed the Nurse-Manager shift report which indicated that a resident had injured another resident during an altercation.

Inspector #627 interviewed the staff member who stated that they had reported the incident to the Administrator.
Inspector #627 interviewed another staff member who stated that if they had documented it on the shift report, they had made the DOC aware.

b) Upon further review of the resident's progress notes, Inspector #627 reviewed a progress note which indicated that a resident had injured another resident. It was identified that the charge nurse was made aware.

Inspector #627 reviewed the day's Nurse-Manager shift report which indicated that the resident was wandering and had a physical altercation with another resident.

Inspector #627 interviewed a staff member who stated that they had documented the incident on the shift report. The staff member stated that the process was to call the DOC at home, and they would decide if this was reportable. The staff member stated they could not recall if they had called the DOC; however, they had documented the incident on the shift report.

Inspector #627 interviewed the DOC, who stated that the Nurse-Manager shift report was to be read to the oncoming staff as well as registered staff. It was also sent to all managers and read on every shift. If something was unclear, the DOC stated that they would call the home if they needed more details. The DOC stated that the process for the home, when there was an incident of resident to resident altercation was to separate the residents, treat any wounds, documented in Point Click Care, and notify the [substitute decision makers (SDMs)]. The DOC further stated that the above incidents had not been reported as in the past, the home had reported all resident altercations, and this had caused the home to be investigated as they were reporting more altercations than other homes. The DOC stated that it was tough to know when to report, and that the Administrator and themselves would decide together if they needed to report an incident.

Inspector #627 interviewed the Administrator who stated that when there was a physical altercation between two residents, they would use the "falls legislation" to determine if the altercation rose to the level of being a critical incident whereby, the resident who had been injured had a significant change to their health due to the altercation. If it did rise to this critical level, then they would report the incident. The Administrator further stated that they had not been made aware of the aforementioned altercation. [s. 24. (1)] (627)

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Ontario regulations (O.Reg.) 79/10, of the Long-Term Care Homes Act 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 or inaction that jeopardizes the health, safety or well being of one or more residents".

During an interview with a staff member, they informed Inspector #627 that they had worked a shift and that during a meal service, they had noticed that a resident had soiled themselves. The staff member stated that they had taken the resident to their room to provide them with continence care and noticed that the appropriate continence care interventions had not been provided. After having provided the resident with continence care, the staff member stated that they had went to verify the documentation sheet for care given and noted that another staff member had signed that they had provided continence care to the resident. The staff member stated that they had reported the incident to the charge nurse.

Inspector #627 interviewed a second staff member who stated they had made the Administrator aware of the incident the following day, during a meeting. The staff member stated that they had brought forth at least twice that the staff member was often neglectful when providing care.

Inspector #627 interviewed a staff member who stated they were not sure if they had provided continence care to the resident as per their care plan. The staff member stated that no one had spoken to them about the incident.

Inspector #627 was provided with a copy of a letter. The letter described a situation that unfolded during a shift, on a specified date. The letter described how a resident was not provided continence care as per their care plan. It was determined that the best action regarding the incident was to inform the DOC and the Administrator. The staff member stated that they had forwarded a copy of the letter to the Administrator.

Inspector #627 reviewed the resident's care plan for toileting. The care plan directed staff to provide the resident with specific continence care interventions.

Inspector #627 interviewed the DOC who stated that the incident had not been reported to the Ministry. The DOC stated that the Administrator and themselves had a meeting with the staff member, whereby the Administrator had asked the staff member if the had provided continence care to the resident and that the staff member had denied not providing continence care to the resident as per their care.

Inspector #627 interviewed the Administrator who stated they could not recall being made aware of this incident prior to receiving the letter from the two staff members. The Administrator stated that they had met with the staff member and a union member, whereby the staff member had stated that they provided continence care to the resident as per the resident's care plan, and that the incident was not reported to the Ministry. [s. 24. (1)]

The severity of this issue was determined to be a level one, as there was no harm or risk of harm. The scope of the issue was a level three, as the issue was widespread. The home had a level three compliance history with related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10:
-Voluntary Plan of Correction (VPC) issued October 26, 2017, (2018_616542_0012); and,
-Compliance Order (CO) issued on November 18, 2018, (2018_746692_0017). (627)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with s. 33 (1) of the Ontario Regulation 79/10.

Specifically, the licensee shall prepare, submit, and implement a plan to ensure that each resident of the home is bathed, at a minimum twice a week, by the method of his or her choice.

The plan must include, but is not limited to, the following:

a) How the licensee will ensure that all residents, including those who require the assistance of two staff, are bathed at a minimum of twice a week using a method of their choice.

b) How the licensee will develop and implement a process to ensure that documentation is maintained if a resident's bath or shower is not completed, or if a resident is bathed using a method other than their preferred choice.

c) How the licensee will ensure that the home's Director of Care and/or Administrator are involved in monitoring and rescheduling any missed baths or showers.

Please submit the written plan, quoting Inspection #2020_752627_0012, and Inspector Sylvie Byrnes, by email to SudburySAO.moh@ontario.ca by September 17, 2020.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

During interviews with Inspector #627, multiple staff members brought forth concern that the staffing levels had not permitted staff to provide care to the residents as per their care plan. A staff member stated that "last night there was only two of us, we had four baths, I gave one full tub bath, the other ones, one refused I did not ask them again, the other two we did not have time, we gave a good bed bath to two residents".

A second staff member stated that when they came in, the home seemed like it was in a "scramble" as staff were trying to complete their duties and the oncoming staff were trying to get report. The staff member stated that baths were deferred due to the lack of staffing. The staff member stated that they were not proud to say that when a bath was refused, it was not offered again and that staff "did not document things that would hurt [them]". The staff member stated that when care was not provided, they had been directed by the Administrator to leave the "check off area blank" and that "usually we put BB for a bed bath".

a) Inspector #627 interviewed a resident who stated that there was hardly any staff on weekends, and this affected the care they received. The resident stated that they were getting up later than they wished. As well, the resident stated that a few weeks ago, they were told that there was no time for a tub bath and that they would receive a bed bath instead.

Inspector #627 reviewed the documentation for the resident for a period of three months and noted that on one occasion, the resident had received a bed bath, and on another occasion, documentation had not been completed

A progress note indicated that on one occasion, when the resident had been going for their bath, they had been told that due to time constraint, their bath

would have to be given quickly. The resident had voiced their disapproval then.

A review of the resident's care plan, for the focus of bathing indicated that staff were to allow a specific time frame when assisting the resident with their bath.

b) Inspector #627 reviewed the sign off documentation sheet indicating the care received for a second resident, for a three-month period and noticed that there was no documentation regarding bath care for three dates; the sign off area were left blank and no progress notes were written, identifying why the documentation had been left blank.

A review of the resident's care plan, for bathing, indicated that the resident was to receive a specific bath twice weekly by staff.

c) The Inspector reviewed the documentation for a third resident which indicated the care received, for a three-month period and noted that on nine occasions, the documentation was left blank and on one occasion, it was indicated that the resident had received a bed bath.

Progress notes indicated that the resident had refused their bath on two occasions.

A review of the resident's care plan, for bathing, indicated that the resident was to receive a shower twice weekly.

d) The Inspector reviewed a progress note for a fourth resident which indicated, "[staff member] reported they where unable to complete resident's bath this afternoon due to short staffing. Charge nurse [made] aware".

e) Inspector reviewed a progress note for a fifth resident which indicated "[staff member] reported they were unable to complete resident's bath this afternoon due to short staffing. Charge nurse aware".

f) The Inspector reviewed progress notes for five residents, for a specific date which indicated "Resident did not receive bath this shift due to time constraint".

Inspector #627 interviewed a staff member who stated that baths were not always completed, or a bed bath would be given when the home was short staffed. They stated that the home was always multiple staff members short, and that on a specific weekend, the home was six staff members short, which was one third of their staff.

Inspector #627 interviewed another staff member who stated that staff would report to them when baths could not be completed due to staffing shortages, and this would be added to the shift report to make the oncoming shift and management aware. The staff member further stated, "I am ashamed to say, the baths are usually not made up".

Inspector #627 interviewed the DOC who stated that when the home was short staffed and baths could not be completed due to time constraints, the staff members were to give the residents a "good" bed bath and the residents would get a bath on their next scheduled bath day. [s. 33. (1)]

The severity of this issue was determined to be a level two, as there was minimal risk of harm. The scope of the issue was a level three, as the issue was widespread. The home had a level two compliance history with previous non-compliance in the last 36 months to different sections of the Ontario Regulation 79/10.
(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Order / Ordre :

The licensee must be compliant with s. 41 of the Ontario Regulation 79/10.

Specifically, the licensee shall prepare, submit, and implement a plan to ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The plan must include, but is not limited to, the following:
a) How the licensee will ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

b) How the licensee will develop and implement a process to ensure that documentation is maintained if a resident's desired bedtime and rest routines is not followed.

c) How the licensee will ensure that the home's Director of Care and/or Administrator are involved in monitoring that each resident of the home preferred bedtime and rest routines are followed.

Please submit the written plan, quoting Inspection #2020_752627_0012, and Inspector Sylvie Byrnes, by email to SudburySAO.moh@ontario.ca by September 17, 2020.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident of the home had his or her desired bedtime and rest routines supported and individualized to promote

comfort, rest and sleep.

A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

During an interview with Inspector #627, a staff member stated that they when they had left the home, on a specific day, after their shift, many residents had not received bedtime (hs) care and were still sitting in their wheelchair. The staff member stated that they recalled that seven residents were not yet in bed and had not been provided with hs care, when they had left.

Inspector #627 reviewed the evening shift report for the above shift, which indicated that seven residents, on one floor had not been provided with hs care and four residents on another floor had not been provided with hs care.

Inspector #627 reviewed a progress note, which indicated "Resident upset this evening/night because it was late and evening staff had not gotten [them] ready for bed yet. Resident had stated that this has happened multiple times now and that [they have] not been getting ready for bed at their preferred time the past few nights".

Inspector #627 reviewed the home's policy "The Care Plan", which indicated that the purposes of the care plan was to "record the resident's own preferences and approach to their care; how do they like to be addressed; do the retire early or late. To answer appropriately the question: Did we meet the needs of this resident as stated in our long- and short-term objectives".

The Inspector reviewed the care plans in effect at the time of the incident, for the focus of preferred bed times, for the above residents and noted that the residents' had preferred bed times.

Inspector #627 interviewed two of the above residents who stated that they were upset as they felt they were always the last one to be assisted to bed, and that at times it was past their preferred bed time, before they were assisted to bed.

The Inspector interviewed a third resident who stated that they often went to bed on their own. The resident said they would then wait for someone to come and

assist them with washing and brushing their teeth.

The Inspector interviewed a forth resident who stated that they often undressed and transferred to bed on their own, although the Physician had warned them against it, as often they had not received help by the time they were ready for bed

Inspector #627 interviewed a staff member who stated that on a specific shift, when they had left, there remained seven residents who were still up and had not received hs care.

Inspector #627 interviewed another staff member who stated they had worked the night shift on a specific date. The staff member stated that when they had arrived for their shift, everyone was scrambling to finish their duties, while on coming staff got report. The staff member stated that residents remained up and had not been provided with hs care yet, as the home was short staffed for the evening shift.

Inspector #627 interviewed the DOC who stated that the residents' care plan for "desired bed time" was to let staff know when the residents wanted to go to bed, and that it should be respected. "I would hope that all residents who want to go to bed, be put to bed and the ones who are able to understand would be told that the staff would come back to provide them with care, and if they dosed off, they would be woken up but only rarely, when there [was] no other choice". [s. 41.]

The severity of this issue was determined to be a level two, as there was minimal risk of harm. The scope of the issue was a level three, as the issue was widespread. The home had a level two compliance history with previous non-compliance in the last 36 months to different sections of the Ontario Regulation 79/10. (627)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must be compliant with s. 51 (2) of the Ontario Regulation 79/10.

Specifically, the licensee shall prepare, submit, and implement a plan to ensure each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

The plan must include, but is not limited to, the following:
a) How the licensee will ensure that all resident of the home, including those who require the assistance of two staff members, who are incontinent have an individualized plan to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

b) How the licensee will develop and implement a process to ensure that documentation is maintained to reflect the time and frequency residents were provided with continence care, as indicated in their care plan.

c) How the licensee will ensure that the home's Director of Care and/or Administrator are involved in monitoring that each resident of the home receives assistance with continence care, according to their individualized plan.

Please submit the written plan, quoting Inspection #2020_752627_0012, and Inspector Sylvie Byrnes, by email to SudburySAO.moh@ontario.ca by September 17, 2020.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

Inspector #627 interviewed a staff member who stated that because of staff shortages, some residents were not toileted or provided with continence care as often as they needed to be. The staff member further stated that they had to tell

residents who were able to ask to be toileted to "hang on" as the wait depended on the other residents "who were going", and that at times, the wait was much too long.

Inspector #627 interviewed a resident who stated that they were not provided with assistance right away when they required to use the toilet and that they frequently had to wait “much too long”.

a) On a specific date, Inspector #627 observed a resident in the dining room for a meal service. After the meal, the resident was assisted to the activity room, where they remained until the next meal service, when they were returned to the dining room. After the meal service, the resident was returned to bed, but was not provided with continence care.

On another day, Inspector #627 observed the resident in the dining room, for a meal service. When the meal was completed, the resident was brought to the activity room where they remained until they were transferred to bed by a staff member.

The Inspector interviewed a staff member who was caring for the resident. They stated that they had provided continence before two meal services.

On a third day, the Inspector observed the resident in the dining room for a meal service. After the meal, the resident was transferred to the activity room. The resident was brought to their room and provided continence care approximately one hour and a half later.

Inspector #627 reviewed the resident care plan and noted for urinary/bowel continence, the resident wore an incontinence product, the staff was to provide assistance as required, check for incontinence every morning, every evening, before and after meals, every nursing round during the night and as required.

Inspector #627 interviewed a staff member who stated that the resident was provided with continence care prior to getting up. The staff member further stated that the resident was usually provided with continence care once more during the day, however, they had not provided continence care to the resident when they returned them to bed as they were unable to provide the care by

themselves and that afternoon shift would provide the resident with continence care.

Inspector #627 interviewed a second staff member who stated that they had not been able to provide the resident with continence care; " I did not have time to toilet [them], we do our best. I had to do the water rounds and answer call bells. I never got to toilet [them]".

Inspector #627 interviewed another staff member who stated that they had not provided the resident with continence care, as they had been changed earlier in the day.

b) On a specified date, a second resident was observed in the dining room for a meal service. After the meal service, the resident was assisted to the activity room where they remained until the next meal service, when they were transferred to the dining room. The resident had not been checked for incontinence or provided with continence care.

On a later date, Inspector #627 observed the resident in the dining room for a meal service. After the meal, the resident was assisted to the activity room, where they remained until the next meal service. The resident was not checked for incontinence or provided with continence care.

Inspector #627 reviewed the resident's care plan which directed staff to provide assistance and to toilet the resident every morning, at bedtime, before and after meals, on every nursing round during the night and as required.

Inspector #627 interviewed a staff member who stated that the resident had been provided with continence care in the morning, and before lunch, as the resident had soiled themselves. The staff member further stated that after lunch, the staff attempted to return all residents to bed, however, there was not enough time to provide continence care to all residents and afternoon shift would be providing the care to the residents who were missed.

Inspector #627 interviewed another staff member who stated that they often missed the between breakfast and lunch continence care because there are not enough staff members.

Inspector #627 interviewed a third staff member who stated that "usually when we return the residents to bed, we provide continence care. It has been crazy, things have to change! We do not have enough time to provide the resident with continence care. We do if we smell they had a bowel movement, but we don't toilet them often enough. Things have to change".

c) On a specific date, Inspector #627 observed a resident in the dining room for a meal service. When the meal was finished, the resident was brought to the activity room where they remained for three hours, when they were returned to their room and left sitting in their chair. The resident was not provided continence care. Inspector #627 asked the resident if they felt their brief was wet, to which the resident replied "yes". Three minutes later, the resident was returned to the activity room, awaiting the next meal service. The resident had not been checked for incontinence or provided with continence care.

At a later date, Inspector #627 observed the resident in the dining room for a meal service. After the meal, the resident was assisted to the TV room. Two hours later, the resident was observed trying to leave the TV room, when a staff member assisted them back to the TV room and told the resident "[the meal] will be here soon". The resident remained in the TV room until the meal service. They were not checked or provided with continence care.

Inspector #627 reviewed the resident's care plan which directed staff to provide assistance for continence care in the morning, at bedtime, before and after meals and when required.

Inspector #627 interviewed a staff member who stated that they had gotten the resident up, however they were short staffed and hadn't had the time to bring the resident back to their room. The staff member further stated that staff would call them if they had noticed that the resident had soiled themselves or had asked to be toileted.

Inspector #627 interviewed another staff member, a short while after they had started their shift. When the Inspector inquired if the resident was provided with continence care, the staff member checked and found the resident to have a soiled continence product. They proceeded to provide the resident with

continence care.

Inspector #627 interviewed the DOC who stated that the expectation was that residents would be brought to a private area or transferred to bed and would be checked for incontinence and provided with continence care if required, in the morning, before and after meals, at bedtime and when required. [s. 51. (2) (b)]

The severity of this issue was determined to be a level two, as there was minimal risk of harm. The scope of the issue was a level three, as the issue was widespread. The home had a level two compliance history with previous non-compliance in the last 36 months to different sections of the Ontario Regulation 79/10.
(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with s. 49 (2) of the Ontario Regulation 79/10.

Specifically, the license must;

1) ensure that when a resident is placed on a head injury routine, the head injury routine is completed and documented in its entirety.

2) re-educate registered staff on the home's fall policy, specifically on how the head injury routine should be completed when a resident is sleeping.

3) document who provided the re-education and who participated. This information shall be provided to the Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident 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.

A complaint was submitted to the Director regarding staff not providing care to residents as a result of short staffing.

a) Inspector #687 reviewed a resident's Head Injury Routine (HIR) specifically related to the resident's fall incidents. Please see WN #1, item #3 for further details.

For a period of approximately four months, Inspector #687 identified that a resident had eight unwitnessed fall incidents, whereby an HIR were initiated. The Inspector further identified that the staff members had partially completed the resident's HIR. The vitals signs were not completed on 19 occasions; "sleeping" was documented.

b) Inspector #687 reviewed a second resident's HIR report, specifically related to the resident's fall incidents. Please see WN #1, item #1 for details.

For a period of approximately four months, Inspector #687 identified that the resident had four unwitnessed fall incidents and HIR were initiated. The Inspector further identified that the staff members had partially completed the resident's HIR. The vital signs were not completed on nine occasions; "sleeping" was documented.

c) Inspector #687 reviewed a third resident's HIR documentation record, specifically related to the resident's fall incidents. Please see WN #1, item #2 for further details.

For a period of approximately four months, Inspector #687 identified that the resident had one witnessed and four unwitnessed fall incidents and HIR were initiated. The Inspector further identified that the staff members had partially completed the resident's HIR. The vitals signs were not completed on ten occasions; "sleeping" was documented.

Inspector #687 reviewed the home's policy "Medical Directive: Head Injury Routine", which indicated that "This directive applies to residents of Nipissing Manor Nursing Home and Retirement Home who had sustained a head injury":

Routine #1: Vital signs - every 15 minutes x 30 minutes
- every hour x 4 hours
- every 6 hours x 24 hours

Routine #2: Vital signs (Resident on any anti-coagulant therapy - Coumadin, Heparin, Fragmin, ASA) - every 15 minutes x 30 minutes
- every hour x 4 hours

- every 6 hours x 48 hours

Inspector #687 interviewed two staff members who stated that when a resident had an unwitnessed fall or had reported that they had hit their head, a HIR would be initiated. The staff member further stated that if the resident was sleeping during a scheduled Head Injury Routine neuro-vital check, "sleeping" would be documented in the HIR documentation record.

Inspector #687 interviewed the DOC who stated that when a resident had an unwitnessed fall, reported a head injury or staff witnessed a resident who sustained a head injury, a HIR routine would be initiated. The DOC stated that the registered staff were to take the residents HIR routine as outlined in the HIR Policy and that the registered staff must wake the resident up to obtain their neuro-vital signs if they were sleeping. [s. 49. (2)]

The severity of this issue was determined to be a level two, as there was minimal harm. The scope of the issue was a level three, as three out of three residents did not have their head injury routines completed in its entirety. The home had a level three compliance history with the related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10:
- Voluntary plan of correction (VPC), inspection #2019_657681_0029, issued on December 10, 2019. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

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

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2nd day of September, 2020

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Sylvie Byrnes

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