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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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159, rue Cedar Bureau 403
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 2021	2021_841679_0001	018276-20, 018277-20, 018278-20, 018279-20, 018280-20, 018281-20	Follow up

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

MICHELLE BERARDI (679), KEARA CRONIN (759), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 11-15, 2021.

The following intakes were inspected upon during this Follow Up Inspection:

- One intake related to Compliance Order (CO) #001 issued during inspection #2020_752627_0012, related to s. 6 (7) of the Long Term Care Homes Act (LTCHA), 2007, regarding plan of care;

- One intake related to CO #002 issued during inspection #2020_752627_0012, related to s. 24 of the LTCHA 2007, regarding reporting to the Director;

- One intake related to CO #003 issued during inspection #2020_752627_0012, related to s. 33 of Ontario Regulation (O.Reg) 79/10, regarding bathing;

- One intake related to CO #004 issued during inspection #2020_752627_0012, regarding s. 41 of O. Reg 79/10, regarding sleep and rest routines;

- One intake related to CO #005 issued during inspection #2020_752627_0012, regarding s. 51 (2) of O. Reg 79/10, regarding continence care and bowel management; and,

- One intake related to CO #006 issued during inspection #2020_752627_0012, regarding s. 49 (2) of O. Reg 79/10, regarding falls prevention and management.

Critical Incident Inspection #2021_841679_0002 was conducted concurrently with this inspection.

A Compliance Order (CO) related to s. 24 of the LTCHA, 2007, identified in concurrent inspection #2021_841679_0002, was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Manager/Resident Assessment Instruments (RAI) Coordinator, Maintenance Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Life Enrichment Coordinator, Personal Support Workers (PSWs), Physiotherapy Assistants, Ward Clerk, Administrative Assistant, and residents.

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

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 33. (1)	CO #003	2020_752627_0012	638
O.Reg 79/10 s. 41.	CO #004	2020_752627_0012	679
O.Reg 79/10 s. 49. (2)	CO #006	2020_752627_0012	638
O.Reg 79/10 s. 51. (2)	CO #005	2020_752627_0012	759
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_752627_0012	638

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. 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 Registered Nurse (RN), who had reasonable grounds to suspect that improper care of a resident had occurred, that resulted in a risk of harm to the resident, immediately reported the incident with the information upon which it was based to the Director.

Compliance order (CO) #002 related to s. 24 (1) of the LTCHA, 2007, from inspection #2020_752627_0012 issued on September 2, 2020, with a compliance due date of October 15, 2020, is being re-issued as follows:

a) A resident appeared to not have received their care, although it had been documented as completed. A RN provided an account of what had been reported to them to the Director of Care (DOC) the following day. The DOC indicated that the incident was reported to the Director four days after the RN provided the account of what had occurred.

The Administrator and DOC indicated that the RN should have called in and reported the incident to the Director via the After Hours line, or could have contacted the DOC.

Sources: “Zero Tolerance Policy on Abuse & Neglect” policy with a review date of August 2020; A resident's progress notes; witness account records; interviews with the DOC and other staff.

b) The licensee has failed to complete step "two" of the CO prior to the compliance due date of October 15, 2020, regarding the required re-education for staff and management on the requirements under s. 24 (1) of the LTCHA 2007, for reporting certain matters to the Director.

Inspector #759 reviewed the education records and identified that not all staff had completed the required education by the compliance due date of October 15, 2020. The Administrator confirmed that the education for staff was completed, although it was not completed prior to the compliance due date.

Sources: In-service Education Training Records; “Zero Tolerance Policy on Abuse & Neglect” policy with a review date of August 2020; interviews with the Administrator and other staff. [759]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when their care needs changed regarding bed rails.

A resident's care plan outlined that they required a bed rail to one side of their bed. The Inspector observed the resident's bed and noted a bed rail engaged on both sides of the bed. In an interview with a Registered Practical Nurse (RPN), they indicated that residents were assessed for bed rail usage and that the resident used bed rails on both sides of the bed to assist the resident and staff.

In an interview with the Nurse Manager/Resident Assessment Instruments (RAI) Coordinator and DOC, it was identified that the resident used bed rails on both sides of the bed, and that it should have been identified within the plan of care.

Sources: A resident's care plan and bed rail assessment; Inspector observations; interviews with the DOC and other staff. [s. 6. (10) (b)]

Issued on this 29th day of January, 2021

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) :	MICHELLE BERARDI (679), KEARA CRONIN (759), RYAN GOODMURPHY (638)
Inspection No. / No de l'inspection :	2021_841679_0001
Log No. / No de registre :	018276-20, 018277-20, 018278-20, 018279-20, 018280-20, 018281-20
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 27, 2021
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

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

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

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 : 001

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

Linked to Existing Order / Lien vers ordre existant: 2020_752627_0012, CO #002;

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 Home's Act (LTCHA), 2007.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that any person who has reasonable grounds to suspect that abuse of a resident or neglect of a resident that resulted in harm or a risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director.

The plan must include but is not limited to:
a) The re-education of a RN on the reporting requirements outlined in s. 24 (1) of the LTCHA, 2007. This process should be documented to include the date and contents of the re-education; and,
b) How the home will audit to ensure that registered staff are aware of and understand the reporting requirements outlined in s. 24 (1) of the LTCHA, 2007. This process should be documented to include: the date of the audit, the result of the audit and any actions taken to rectify concerns identified in the audit. Conduct and document the audit's until no further concerns are identified in the audits for a two week period.

Please submit the written plan for achieving compliance for inspection #2021_841679_0001 by February 9, 2021.

Grounds / Motifs :

1. The licensee has failed to ensure that a Registered Nurse (RN), who had reasonable grounds to suspect that improper care of a resident had occurred, that resulted in a risk of harm to the resident, immediately reported the incident with the information upon which it was based to the Director.

Compliance order (CO) #002 related to s. 24 (1) of the LTCHA, 2007, from inspection #2020_752627_0012 issued on September 2, 2020, with a compliance due date of October 15, 2020, is being re-issued as follows:

a) A resident appeared to not have received their care, although it had been documented as completed. A RN provided an account of what had been reported to them to the Director of Care (DOC) the following day. The DOC indicated that the incident was reported to the Director four days after the RN

provided the account of what had occurred.

The Administrator and DOC indicated that the RN should have called in and reported the incident to the Director via the After Hours line, or could have contacted the DOC.

Sources: "Zero Tolerance Policy on Abuse & Neglect" policy with a review date of August 2020; A resident's progress notes; witness account records; interviews with the DOC and other staff.

b) The licensee has failed to complete step "two" of the CO prior to the compliance due date of October 15, 2020, regarding the required re-education for staff and management on the requirements under s. 24 (1) of the LTCHA 2007, for reporting certain matters to the Director.

Inspector #759 reviewed the education records and identified that not all staff had completed the required education by the compliance due date of October 15, 2020. The Administrator confirmed that the education for staff was completed, although it was not completed prior to the compliance due date.

Sources: In-service Education Training Records; "Zero Tolerance Policy on Abuse & Neglect" policy with a review date of August 2020; interviews with the Administrator and other staff. [759]

An order was made by taking the following factors into account:

Severity: There was no harm identified related to late reporting of an incident of improper care.

Scope: The scope of this non-compliance was isolated, as it applied to one incident reviewed.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 24 (2) of the Long-Term Care Home's Act, 2007. This subsection was issued as a CO on September 2, 2020, during inspection #2020_752627_0012 with a compliance due date of October 15, 2020. In the past 36 months, nine COs were issued to different sections of the legislation, all

of which have been complied. (638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2021

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:

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

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 27th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Michelle Berardi

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