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
Oct 20, 2021	2021_824736_0018	012834-21, 014849-21	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

AMANDA BELANGER (736)

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): October 12-15, 2021.

During the course of the inspection, the following logs were inspected:

-one intake related to a complaint submitted to the Director regarding the storage of controlled substances; and,

-one intake related to a complaint submitted to the Director related to the provisions of care to a resident.

A CIS inspection #2021_824736_0019 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse(s)(RNs), Registered Practical Nurse(s) (RPNs), Personal Support Worker(s)(PSWs), and residents.

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

PLEASE NOTE: Non-compliance related to s. 6 (7) of the Long-Term Care Homes Act 2007, identified in Critical Incident Inspection #2021_824736_0019, was issued in this report.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Reporting and Complaints

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

2 WN(s)
1 VPC(s)
0 CO(s)
0 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided care as set out in their plans of care.

a) The resident's plan of care indicated that due to responsive behaviours, the resident was to have a specific intervention in place. The Inspector observed the resident without the intervention in place.

The DOC indicated that by staff not implementing the intervention for the resident, care was not provided as per the plan of care.

There was minimal risk of harm to the residents in the home, by staff not providing care to the resident as per the plan of care.

Sources: Inspector observations; the resident's care plan and progress notes; interview with the DOC, and other staff.

b) The resident's plan of care indicated that they required a specific intervention and that staff were to ensure that the resident had that intervention in place while in their room.

The PSW indicated that when the resident was brought back to their room, the resident was not always put on their required intervention, as per their plan of care.

The DOC confirmed that the resident required the specific intervention, and if it was noted to not be in place, care would not have been provided as per the plan of care.

Sources: The resident's progress notes and care plan; interviews with the PSW, DOC and other staff. [s. 6. (7)]

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 to ensure that care is provided to residents as per their plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept of verbal complaints received by the home.

a) The resident's family member brought forward a complaint to registered staff that the resident did not have an intervention in place.

b) The resident's family member also brought forward a complaint to staff related to the conduct of a staff member towards the resident.

The DOC indicated that there had been no records kept of these complaints or the follow up, and that there should have been.

Sources: The resident's progress notes; licensee policy titled "Reporting and Complaints", interview with DOC and other staff. [s. 101. (2)]

Issued on this 21st day of October, 2021

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

Original report signed by the inspector.