Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 22, 2018 | 2018_668543_0010 | 005128-17, 006269-17, 006951-17, 008971-17, 009331-17, 009381-17, 010385-17, 010911-17, 011397-17, 012101-17, 015568-17, 021847-17, 022082-17, 022710-17, 022987-17, 024639-17, 027856-17, 003276-18 | Critical Incident System |

### Licensee/Titulaire de permis

The Board of Management for the District of Nipissing East
400 Olive Street NORTH BAY ON P1B 6J4

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

Cassellholme
400 Olive Street NORTH BAY ON P1B 6J4

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

TIFFANY BOUCHER (543), LOVIRIZA CALUZA (687), MICHELLE BERARDI (679)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): March 26-29, 2018 and April 3-6, 2018.**

**The following intakes were inspected during this Critical Incident Systems (CIS) inspection;**

**Seven intakes related to Abuse.**

**One intake related to Responsive Behaviours.**

**Four intakes related to Falls.**

**One intake related to Medication administration.**

**Two intakes related to Elopement.**

**Three intakes were assigned to the inspection however were not completed.**

**A complaint inspection #2018_668543_0011 was conducted concurrently with this Critical Incident System inspection.**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Clinical Nursing Manager, Resident Services Coordinator, Administrative Assistant, Police officer, Food Service Worker, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).**

**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, reviewed relevant health care records, internal investigation notes, as well as reviewed numerous licensee policies, procedure and programs.**

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

**Falls Prevention**
**Hospitalization and Change in Condition**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**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 there was a written plan of care for each resident that set out clear direction to staff and others who provided direct care to the resident.

A Critical Incident (CI) report was submitted to the Director for alleged staff to resident neglect. The CI report identified that PSW #135 found resident #017 soiled in the afternoon. Resident #017 indicated to PSW #135 that they had not been changed since 2100 the night prior.

Inspector #679 reviewed resident #017's care plan. It was identified under the "Dressing" focus, to wake resident #017 up at a specific time as per their request. Additionally, it was identified under the "Personal Preference" focus, that the resident had a preferred wake time in the morning, which was contrary to the "Dressing" focus time request.

In an interview with PSW #148 they identified that they used resident #017's care plan to reference their care needs. Inspector #679 and PSW #148 reviewed the care plan, specific to their preferred wake time. PSW #148 identified that the care plan had not provided clear direction to staff.

In an interview with RPN #142 they identified that resident care plans are used by staff to provide care, and to find out information about the resident. RPN #142 and Inspector #679 reviewed resident #017's care plan specific to their preferred wake time. RPN #142 identified that it had not provided clear direction. RPN #142 confirmed that the care plan should provide clear direction.

Inspector #679 and RN #123 reviewed resident #017's care plan. RN #123 confirmed that the care plan provided unclear direction related to resident #017's preferred wake time and identified that resident care plans should provide clear direction to staff. [s. 6. (1) (c)]

2. 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 CI was submitted to the Director on a date in 2017, related to allegations of staff to resident neglect. According to the CI report, on a date in 2017, resident #022 was heard by staff calling out for help, staff received the resident in their room on the floor, with an injury.

Inspector #687 reviewed resident #022's progress notes, which noted that resident #022 had been left unattended in their room and they had removed a safety device. Resident #022 was found on the floor, with an injury.

Inspector #687 reviewed resident #022's care plan, which identified that resident #022 was at risk for falls characterized by a history of falls, injury and multiple risk factors related to physical limitations.

Inspector #687 reviewed the "What's Happening Book", a note that indicated that resident #022 should not be left unattended for safety reasons.

Inspector #687 interviewed PSW #118, who indicated that resident #022 should not be left unattended and that staff would bring the resident where they could be monitored closely.

Inspector #687 interviewed PSW #135, who verified that there was a note in the communication binder to inform all staff that resident #022 should not be left unattended, as the resident was removing their safety device and was a high risk for falls.

Inspector #687 interviewed RPN #124, who verified that a note was posted in the "What's Happening Book" indicating that resident #022 would not be left unattended in their room.

Inspector #687 interviewed RN #123, who indicated that the "What's Happening Book" was also referenced as to what should be included in the care plan of residents. RN #123 verified that all staff were to be aware of any updates or changes in the resident's care plan and to be aware of the information posted in the "What's Happening Book". [s. 6. (7)]

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

A CI report was submitted to the Director for an unexpected death. The CI report identified that on a date in 2017, resident #014 sustained a fall and was injured. The resident was sent to the emergency room for assessment. The CI report indicated that resident #014 was to be monitored upon their return to the home.

Inspector #679 reviewed the monitoring record for resident #014. It was identified that on two occasions, two specific parts of the record were not documented.

A review of an email contained within the home's file regarding resident #014's fall identified that the resident was to be monitored at specific intervals.

In an interview with RN #123, they verified that the monitoring documentation should have been completed in its entirety. [s. 6. (9) 1.]

***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 there is a written plan of care for each resident that set out clear direction to staff and others who provided direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

**WN #2: 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's policy titled, "Abuse, Neglect and Retaliation Prevention" (A 4.0), was complied with.

Inspector #543 reviewed a CI report that was reported to the Director, on a date in 2017, related to alleged staff to resident neglect.

According to the CI report, RPN #124 reported to RN #125 that PSW #121 had not attended to the needs of resident #015. The CI report, described that the night shift staff had received resident #015 still up, soiled and agitated.

According to the Ontario Regulation's 79/10, neglect is defined 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 of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #543 reviewed a letter addressed to PSW #121. This letter indicated that an investigation was conducted regarding substandard performance that had occurred on a date in 2017, towards resident #015. The letter identified that resident #015 was overheard asking for assistance several times during the shift that PSW #121 worked. The letter also indicated that it was reported that PSW #121, had not provided care for resident #015, and the resident was received by the night shift staff soiled.

The Inspector reviewed the home's internal investigation summary. This summary indicated that PSW #126 indicated that the resident had impaired skin integrity as a result of being left soiled.

The Inspector reviewed the home's "Abuse, Neglect and Retaliation Prevention" (A 4.0) policy, with a revision date of February 2017. The policy indicated that the home was committed to zero tolerance of abuse or neglect at all times, and in all circumstances. The policy indicated that it applied to all persons, staff, contractors, students, volunteers, families, visitors, board members, and individuals that are involved with the care of the resident and/or the safe operation of the home.

Inspector #543 interviewed RN #123 regarding the incident that occurred on a date in 2017, related to the alleged neglect of resident #015. They verified that PSW #121's behaviour had not complied with the home's "Abuse, Neglect and Retaliation Prevention policy". [s. 20. (1)]

2. A) Inspector #679 reviewed a CI report that was submitted to the Director on a date in 2017, for an incident of alleged staff to resident neglect. The CI report identified that PSW #135 found resident #017 soiled in the afternoon. Resident #017 indicated to PSW #135 that they had not been changed since the night prior.

A review of a written documentation identified that the home had determined "within reasonable certainty" that resident #017 was neglected by PSW #145. The document then identified that the actions by PSW #145 violated the home's Abuse, Neglect and Retaliation Prevention policy.

Inspector #679 interviewed PSW #135 who identified that they found resident #017 soiled when they attended to them in the afternoon. PSW #135 identified that resident #017 told them that they had not received care.

Inspector #679 interviewed PSW #145 who identified that they had checked on resident #017 and they were not soiled. PSW #145 identified that they believed they were respecting the residents wishes to rest and that they knew that resident #017 would receive their care in the afternoon.

In an interview with RN #123 they identified that the neglect was substantiated.

B) A review of the CI report identified that PSW #135 observed resident #017 to be saturated with urine on a date in 2017. The CI report further identified that RN #113 was made aware of the incident more than three hours later.

In an interview with PSW #135 they identified that they contacted RN #113 at the end of

their shift. PSW #135 identified they had not reported it right away as they did not know if the situation constituted neglect.

A review of the home's policy entitled "Abuse, Neglect and Retaliation Prevention" last revised February 2017, identified that any person must immediately report to a supervisor all suspected, alleged or witnessed incidents of resident abuse or neglect, regardless of their personal judgment that it may not be valid.

In an interview with RN #113 they identified that they were notified by PSW #135 of the incident. RN #113 identified that they had completed the investigation and notified management. RN #113 identified that staff were to bring forth any allegations of abuse or neglect immediately.

In an interview with Inspector #687, RN #123 identified that any incident of abuse or neglect were to be reported immediately to the RN supervisor. [s. 20. (1)]

3. Inspector #687 reviewed a CI report that was submitted to the Director on a date in 2017, related to allegations of physical abuse by resident #006 towards resident #001 that had occurred the day prior to the report submitted to the Director.

Inspector #687 reviewed resident #006's progress notes which noted that on a date in 2017, RN #133 documented that there was an increased suspicion that resident #006 may have caused harm to resident #001.

Inspector #687 interviewed RPN #140, who verified that their understanding of mandatory reporting was that they were to immediately report the allegation to the RN for further action.

Inspector #687 interviewed RPN #150, who verified that for any allegations of abuse, the RPN must report the allegation of abuse to their immediate supervisor.

Inspector #687 interviewed RN #133, who verified that their understanding of the mandatory reporting was if there was a suspicion of abuse, 911 would be called, the ministry would be notified and immediate notification to their manager on-call was required. The RN verified to the Inspector that, "I should have done that but, I did not". [s. 20. (1)]

***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 the home's policy titled, "Abuse, Neglect and Retaliation Prevention" (A 4.0), is complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for a resident.

Inspector #679 reviewed a CI report that was submitted to the Director for a medication incident/adverse drug reaction. The CI report identified that RPN #117 administered resident #008 thirteen of resident #021's medications.

A review of the electronic documentation identified that resident #008 was given "medications that they did not normally receive".

The progress notes identified that the resident's blood pressure had decreased, that the resident had experienced negative side effects and was sent to the emergency room for treatment.

A review of home's investigation documents identified that resident #008 was given resident #021's medications in error. A written interview within the investigation records indicated that RPN #117 administered medications to resident #008 after verbally confirming the resident's identity.

A review of the home's policy entitled "The Medication Pass: 3-6" last revised January, 2018, identified that each resident was to receive the correct medication in the correct prescribed dosage, at the correct time, and by the correct route. The policy further indicated that staff were to identify the resident using two identifiers, such as photo, armband, or other staff, and never by verbal response.

In an interview with Inspector #679, RPN #117 identified that they administered resident #008, another resident's medication in error after verbally confirming the resident's identity. RPN #117 confirmed that medications should be given in accordance with the directions outlined by the prescriber.

In an interview with RN #123, they identified that RPN #117 administered resident #008 incorrect medications, for which the resident experienced symptoms and was transferred to the emergency department. RN #123 verified that it was the expectation that residents were administered medications as prescribed by the physician. [s. 131. (1)]

***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 no drug was used by or administered to a resident in the home unless the drug had been prescribed for a resident, to be implemented voluntarily.***

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**Issued on this 23rd day of May, 2018**

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

**Original report signed by the inspector.**