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 prévue 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2018	2018_565647_0029	000213-18, 007382-18, 007383-18, 007385-18, 009134-18, 009879-18, 010285-18, 013345-18, 016547-18, 017622-18, 018061-18, 023917-18, 028313-18, 028541-18	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

JENNIFER BROWN (647), AMY GEAUVREAU (642)

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): November 5 - 9, 2018.

The following intakes were completed in this Critical Incident System (CIS) Inspection:
-one related to an Outbreak,
-five related to related to Staff to Resident Abuse,
-one related to visitor to resident abuse,
-three related to resident to resident abuse,
-one related to resident elopement,
-two related to fall resulting in injury,
-one related to a medication incident.

A Complaint Inspection, #2018_565647_0030 was conducted concurrently with this CIS Inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Unit Coordinator, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Residents, and Substitute Decision Makers.

During the course of the inspection, the inspector conducted observation in resident home areas, observation of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **2 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 the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident Report (CIS) report was received by the Director, which indicated that resident #008 had eloped from the home for more than three hours.

The CIS further indicated the home received a phone call from the North Bay police department, to inform the home that a member of the community had called them after finding resident #008 in a nearby parking lot. The member of the community had known resident #008 resided at Cassellholme.

A review of the plan of care which included the progress notes for resident #008 indicated that on two occasions, resident #008 had vocalized and displayed actions to their desire to leave.

A review of the written plan of care indicated that resident #008 had been identified as a high elopement risk and hourly checks were put into place.

An interview with direct care staff member #105 who had been responsible for resident #008's care on the day of the elopement indicated that they were aware that resident #008 had been required to be checked every hour to ensure their whereabouts. Direct care staff member #105 further indicated during the interview however, that they had not checked the resident every hour to ensure resident #008 was still in the home as they were taking care of other residents.

The Director of Care (DOC) indicated to the Inspector that the direct care staff member had been required to ensure they visualized resident #008 every hour to ensure their whereabouts and safety. The DOC confirmed that resident #008's plan of care was not followed related to hourly checks which directly impacted resident #008 being able to leave the home undetected. [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 the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

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

A CIS report was submitted to the Director, which identified that on an identified date, resident #017 received four medications that had been prescribed for resident #001.

The Inspector reviewed the electronic medication administration record (eMAR) for resident #017 which identified they had not been precribed the identified medications.

The Inspector reviewed resident #017's progress notes and identified a notation, where the resident received another resident's prescribed medications and had been sent to hospital for assessment, and later returned to the home.

The Inspector reviewed the medication incident report which indicated that Registered staff member #121 was administering medications to resident #017 and had

unintentionally opened resident #001's medication bin which had been directly beside resident #017's medication bin. Registered staff member #121 indicated in their statement of account that they had not ensured all of their medication checks were completed prior to administration. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

a) A medication incident was selected by the Inspector as part of the medication review and identified an incident, where resident #019 had not received two of their scheduled medications.

The Inspector reviewed the eMAR for resident #019 which identified it had been documented that they had received the two medications. During medication administration by the following shift, it had been identified that these medications had still been in resident #019's medication bin.

Inspector #647 reviewed resident #019 health care records and identified a physician's order for the above medications, which directed staff to administer at an identified time.

b) A further medication incident was selected by the Inspector as part of the medication review which identified an incident, where resident #018 had not received their one scheduled medication.

The Inspector reviewed the eMAR for resident #018 which identified it had been documented that they had recieved the identified medication. During medication administration by the following shift, it had been identified that this medication had still been in resident #018's medication bin.

Inspector #647 reviewed resident #018's health care records and identified a physician's order, which directed staff to administer the identified medication at an identified time.

The home's policy titled "The Medication Pass", section 3, Policy 3-6, dated February 2017, indicated that each resident receives the correct medication in the correct prescribed dosage, at the correct time and by the correct route.

In an interview with Inspector #647, the DOC indicated registered staff were expected to administer medications based on the prescriber's orders and if they weren't it was

considered a medication incident which would be identified in a medication incident report. [s. 131. (2)]

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 is used by or administered to a resident in the home unless the drug has been prescribed and to ensure that drugs administered to residents are in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meet annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The Director received a CIS report, which identified a medication error where resident #017 had received medication that they had not been prescribed.

During an interview with the DOC, it had been acknowledged that the medication management system had been reviewed by the Inspector, and that the annual evaluation for 2018 had not been required as of yet, however it had been identified that the annual evaluations for 2016 or 2017 had not been completed to evaluate the effectiveness of the medication management system in the home. [s. 116. (1)]

Issued on this 16th day of November, 2018

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

Original report signed by the inspector.