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
Feb 25, 2020	2020_782736_0005	002311-20	Complaint

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

AMANDA BELANGER (736), KEARA CRONIN (759)

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): February 18-21, 2020.

During the course of this Complaint Inspection, the following log was inspected:
-one log related to a complaint submitted to the Director related to an allegation of staff to resident abuse.

A Critical Incident System Inspection #2020_782736_0006 was conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance of a Voluntary Plan of Correction (VPC) related to s. 24 (1) of the LTCHA 2007, was identified in a concurrent inspection, #2020_782736_0006, and was issued in this inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), acting Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the Inspector(s) reviewed internal investigation notes, relevant resident health records, relevant staff files, licensee policies and observed the provisions of care.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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. 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that allegations of resident abuse were immediately reported to the Director.

As defined in the Ontario Regulation (O.Reg) 79/10, emotional abuse is "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident". Furthermore, verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

A complaint was submitted to the Director regarding an incident involving resident #002. The complainant indicated that Personal Support Worker (PSW) #110 allegedly "manhandled" the resident and spoke to the resident rudely.

Inspector #759 reviewed the home's internal investigation notes regarding this incident. The Inspector identified an email correspondence written by Registered Practical Nurse (RPN) #109 on a specified date, that was addressed to the Director of Care (DOC) and Unit Coordinator (UC) #111. It indicated that PSW #110 was rough when repositioning resident #002 and RPN #109 heard PSW #110 say that resident #002 "should not ring

the call bell unless it's for an emergency". It further indicated that resident #002 stated that they did not want PSW #110 back in their room as they were afraid.

During an interview with Inspector #759, RPN #109 indicated that they heard PSW #110's voice getting loud and that it sounded like the PSW was getting flustered and bossy; resident #002 was worried about PSW #110 acting out against them.

Inspector #759 spoke with resident #002, they stated that they felt that PSW #110's actions were abusive towards them. They further indicated that PSW #110 told them to go to the bathroom in their pants.

Inspector #759 reviewed the policy titled "Abuse, Neglect and Retaliation Prevention" last revised July 25, 2019, it indicated that staff were to report all "alleged, suspected or witnessed incidents of abuse or neglect" externally using the Critical Incident System.

Inspector #759 interviewed the UC #111, who indicated that suspected abuse was reported to the Ministry of Long-Term Care.

Inspector #759 interviewed the acting DOC who indicated that this incident was not reported to the Ministry of Long-Term as they thought it was rudeness and did not think it was abuse.

2. A Critical Incident (CI) report was submitted to the Director on a specified date, for an allegation of visitor to resident abuse.

The CI report indicated that a private care worker had indicated to a PSW within the home that a visitor may have been abusive towards resident #001. The CI report indicated that the allegation had been made two days prior to the report being submitted to the Director, and, that the Ministry of Long Term Care, after hours pager, had not been contacted regarding the allegation.

Inspector #736 reviewed the home's internal investigation package, which indicated that on a specified date, two days before the report was submitted to the Director, the RN supervisor was aware of the allegation of visitor to resident abuse.

In an interview with RN #107, they indicated to the Inspector that they were made aware of an allegation of resident abuse on the specified date by PSW #105. The RN further indicated to the Inspector that they had made the manager on call, the Chief Executive

Officer (CEO), aware of the allegation, and the direction was given to notify the police, and that notification of the Ministry of Long Term Care “could wait until the next day”.

A review of the licensee’s policy titled, “Abuse, Neglect and Retaliation Prevention”, #05-03, last revised July 25, 2019, directed staff that anyone who had reasonable grounds to suspect that any of the mandatory reporting elements may have occurred, were to report the matter to the Director. The licensee’s policy further directed that an immediate report was to be made to the MOHLTC Director when there was a reasonable suspicion that abuse of a resident by anyone that resulted in hard or risk of harm to the resident had taken place.

In an interview with the acting DOC, they indicated that all allegations of resident abuse were to be immediately reported to the Director of Long Term Care by an RN supervisor or by themselves. The acting DOC further indicated that the allegation of visitor to resident abuse was not reported immediately and should have been.

In an interview with the CEO, they indicated that they had been made aware of an allegation of resident to visitor abuse on the specified date by RN #107. The CEO further indicated that allegations of abuse were to be reported immediately. The CEO indicated that the allegation of visitor to resident abuse of resident #001 should have been reported to the Director immediately. [s. 24. (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 all allegations of resident abuse are immediately reported to the Director, to be implemented voluntarily.

Issued on this 25th day of February, 2020

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

Original report signed by the inspector.