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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Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
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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
Jun 18, 2021	2021_669642_0015	001634-21, 001970-21, 003927-21, 004216-21, 004693-21, 005014-21, 006616-21	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

AMY GEAUVREAU (642), STEVEN NACCARATO (744), TIFFANY BOUCHER (543)

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): May 10-14, 17-19, 2021.

The following intakes were inspected during this Critical Incident System (CIS) inspection:

Four Critical Incidents: that were submitted to the Director regarding care concerns about staff to resident alleged improper care, neglect and potential abuse.

Four Critical Incidents: that were submitted to the Director related to resident falls with injury.

A concurrent Complaint Inspection #2021_669642_0014, was conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Operations, Chief Executive Officer (Administrator), Director of Clinical Services (DOC), Co-Director of Care (Co-DOC), Unit Coordinators, Infection Control Manager, Resident and Family Navigator, RAI Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, family members, and residents.

The Inspector(s) also conducted a tour of the resident care areas, reviewed relevant resident records and policies, investigations notes and interviews and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

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

- **3 WN(s)**
- **2 VPC(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure two residents were protected from neglect by a Personal Support worker (PSW).

Section 2 (1) of the Ontario Regulations 79/10 defines neglect as, “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.”

A Critical Incident (CI) report was submitted to the Director that indicated that a PSW had neglected to provide care to two specific residents.

A review of the home’s internal investigation notes identified that a PSW had reported care concerns about another PSW, when one of the resident's was found to have not been provided specific personal care. On further review, that resident's Substitute Decision Maker (SDM), identified that on a different day, when they arrived on the unit, they found this resident had not been provided specific personal care. The investigation identified the same PSW had worked those shifts.

Additionally, the internal investigation notes identified that the same PSW neglected to provide care for another resident. This resident was left for long periods of time without being provided personal care.

An interview with this PSW verified that they had not provided care to these two residents.

In an interview with the Assistant Director of Care (ADOC) they verified that these two residents had been neglected by this PSW.

Sources: Critical Incident; Abuse Policy titled, Abuse, Neglect and retaliation Prevention; internal investigation notes, interviews with ADOC, Unit Coordinator and the PSW. (543) [s. 19.]

2. The licensee has failed to ensure a resident was protected from neglect by a PSW.

A CI report was submitted to the Director, that identified this PSW had not provided any personal care to a resident, on a specific date.

A review of the investigation notes identified a Unit Coordinator had met with the PSW, who had admitted that they did not provide personal care to a resident on specific days.

In an interview with a Unit Coordinator they stated that after their investigation, this PSW had admitted they had not provided the resident with personal care, and it was identified as neglect.

Sources: Critical Incident; Abuse Policy titled, Abuse, Neglect and retaliation Prevention; the disciplinary letter for this PSW; interviews with a Unit Coordinator, and other staff. (543) [s. 19.]

3. The licensee has failed to ensure that two residents were protected from neglect by a PSW.

A CI report was submitted to the Director, that identified a PSW had not provided any personal care to two specific residents.

Interviews with two other PSWs identified that when they started their shift, a resident was identified as not having their personal care completed. Also, another resident had asked one of the PSWs, if they were going to be provided their personal care since they had not had any care provided as well. The two PSWs assisted this resident with their personal care, and identified this resident had not been provided any personal care during a specific shift.

An interview with a Unit Coordinator, who had completed the investigation and review of the camera footage, identified when they interviewed this PSW about these two residents care, the PSW admitted that they had “forgot” to provide care to one of the residents, and stated the other resident refused, but admitted they had not provided any personal care

for them.

In an interview with the Director of Care (DOC), they stated that after their investigation, this PSW had received a disciplinary letter identifying the allegations of neglect had been substantiated.

Sources: Critical Incident; Abuse Policy titled, Abuse, Neglect and retaliation Prevention; a disciplinary letter for this PSW; camera footage notes; interviews with DOC, a Unit Coordinator; PSWs, and other staff. (642) [s. 19. (1)]

4. The licensee has failed to ensure a resident was protected from physical abuse by a PSW.

Section 2 (1) of the Ontario Regulations 79/10 defines physical abuse as, “the use of physical force by anyone other than a resident that causes physical injury or pain.”

A CI report was submitted to the Director that identified that a PSW had abused a specific resident while providing care, that resulted in an injury.

A review of this resident's progress notes identified the resident had stated they had a sore area, and they were upset about it. Staff completed an assessment and identified an injury.

A review of the home’s internal investigation notes identified that this resident had been abused by this PSW.

An interview with the ADOC they indicated that abuse was substantiated, despite the abuse being unintentional.

Sources: Critical Incident; Abuse Policy titled, Abuse, Neglect and retaliation Prevention; internal investigation notes, progress notes; interviews with ADOC, and other staff. (543) [s. 19. (1)]

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. (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 a device for a resident was on and working.

A Critical Incident (CI) report was submitted to the Director related to a resident having a incident which resulted in an injury.

A review of this resident's care plan identified that the device was added to this residents care plan on a specific day.

A review of this resident's progress notes, identified on so many days after the device was initiated, an RN had written in a progress note, that the device was not in use, and it had to be added to this resident's plan.

An interview with the DOC, identified the staff should have been following this resident's plan of care, and a device should have been initiated on the earlier date, they could not understand why there was no device working after that specific day.

Sources: CI report, a resident's care plan; Policy titled, Admission Plan of Care; interview with 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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (3) Where a resident is being restrained by a physical device when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in section 36 of the Act, the licensee shall ensure that,
(a) the resident is monitored or supervised on an ongoing basis and released from the physical device and repositioned when necessary based on the resident's condition or circumstances; O. Reg. 79/10, s. 110 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who had a specific physical device; was monitored/ supervised on an ongoing basis, released from the physical device and repositioned when necessary based on the resident's condition or circumstances.

The Inspector reviewed internal investigation notes, related to a CI report that identified on specific days, a PSW neglected to provide care for a resident. The resident was left in a device for long periods of time without care being provided.

According to the home's Restraint and Personal Assistance Devices (PASDs) Policy and Procedure, residents' who are using a specific device must be checked to ensure comfort and safety, and repositioned at certain times.

In interviews with the PSW and the ADOC, they verified that the resident was left in their physical device for long periods of time without care being provided.

Sources: Critical Incident; Restraint and Personal Assistance Devices (PASDs) Policy and Procedure; internal investigation notes, interviews with ADOC, and the PSW and other staff. [s. 110. (3) (a)]

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 when a resident is using a specific physical device that the resident is monitored or supervised on an ongoing basis and released from the physical device and repositioned when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

Issued on this 7th day of July, 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) :	AMY GEAUVREAU (642), STEVEN NACCARATO (744), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2021_669642_0015
Log No. / No de registre :	001634-21, 001970-21, 003927-21, 004216-21, 004693-21, 005014-21, 006616-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 18, 2021
Licensee / Titulaire de permis :	The Board of Management for the District of Nipissing East 400 Olive Street, North Bay, ON, P1B-6J4
LTC Home / Foyer de SLD :	Cassellholme 400 Olive Street, North Bay, ON, P1B-6J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jamie Lowery

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

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To The Board of Management for the District of Nipissing East, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee must:

--Ensure specific residents' are protected from Abuse and Neglect;

--Ensure these specific residents are receiving their specific personal care, as per their care plan;

--Audit the specific PSWs for a two week time period, to ensure that they are completing care of residents as per the residents care plan; and

--Document the audits completed, including the date; name and designation of the staff member who conducted the audit(s); any variances found; and corrective action taken and provide the records to an Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure two residents were protected from neglect by a Personal Support worker (PSW).

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reported care concerns about another PSW, when one of the resident's was found to have not been provided specific personal care. On further review, that resident's Substitute Decision Maker (SDM), identified that on a different day, when they arrived on the unit, they found this resident had not been provided specific personal care. The investigation identified the same PSW had worked those shifts.

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care to one of the residents, and stated the other resident refused, but admitted they had not provided any personal care for them.

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Sources: Critical Incident; Abuse Policy titled, Abuse, Neglect and retaliation Prevention; a disciplinary letter for this PSW; camera footage notes; interviews with DOC, a Unit Coordinator; PSWs, and other staff. (642)

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(642)

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An Order was made by taking the following factors into account,

Severity: Staff neglected to provide specific personal care to residents during specific shifts. On another shift one resident received a physical injury. The non-compliance's in these critical incidents identified minimal harm towards the residents.

Scope: The scope of this non-compliance was identified as widespread because five out of five alleged neglect/abuse critical incidents inspected identified non-compliance.

Compliance History: There was no non-compliance issued to the home related to the s. 19 (1) of the LTCHA in the past 36 months. (642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 16, 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 18th day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amy Geauvreau

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