Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
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Original Public Report

Report Issue Date: February 27, 2023	
Inspection Number: 2023-1535-0002	
Inspection Type: Critical Incident System	
Licensee: The Board of Management for the District of Nipissing East	
Long Term Care Home and City: Cassellholme, North Bay	
Lead Inspector Ryan Goodmurphy (638)	**Inspector Digital Signature** Ryan C Goodmurphy Digitally signed by Ryan C Goodmurphy Date: 2023.02.28 11:14:36 -05'00'
Additional Inspector(s) Karen Hill (704609) Samantha Fabiilli (000701) also attended the inspection	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
January 16 - 20, 2023.

The following intake(s) were completed:

- One intake related to an incident of alleged staff to resident neglect;
- Two intakes related to incidents of alleged staff to resident abuse;
- Three intakes related to incidents of resident to resident responsive behaviours;
- One intake related to an incident of improper resident care; and
- Two intakes related to falls which resulted in injury.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (2) (b)

1. The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Specifically, the licensee did not ensure that signage was posted at the entrance to a resident's room or bed space, which indicated the enhanced IPAC measures necessary, as was required by Additional Requirement 9.1 (e) under the IPAC Standard.

An Inspector observed a caddy containing personal protective equipment (PPE) hanging on the door of a resident's room. There was no signage posted to indicate the required "Additional Precautions" at the entrance to the resident room or their bed space. A RPN identified that the resident was placed on isolation and that staff were aware of the requirements, but the signage had not been put up. Upon following up, the additional precautions sign was observed posted at the entrance to the resident's room.

There was low risk to the resident, at the time of the non-compliance, when the home did not ensure that Additional Precautions signage was posted for the resident, as the appropriate PPE was located outside the room and staff demonstrated an awareness of the Additional Precautions required.

Sources: Observations of resident home area and bed space; the resident's health care records; and an interview with a RPN.

Date Remedy Implemented: January 17, 2023. [638]

2. An Inspector observed a caddy containing PPE hanging on the door of a resident's room. An "Additional Precautions" sign was not posted at the entrance to the resident room or bed space. A Personal Support Worker (PSW) indicated that the resident required isolation precautions and that the signage was there and must have been removed. The following day a precautions sign was observed posted at the entrance to the resident's room.

There was low risk to the resident at the time of the non-compliance, when the home did not ensure that Additional Precautions signage was posted for the resident. The appropriate PPE was located outside the room and staff demonstrated an awareness of the Additional Precautions required.

Sources: Observations of the resident home area, room and bed space; the resident's care plan and visual bedside kardex; and interview with a PSW.

Date Remedy Implemented: January 17, 2023. [704609]

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that they carried out every operational or policy directive that applied to the long-term care home, related to Personal Protective Equipment (PPE) requirements for outbreak areas.

The Minister's Directive: COVID-19 response measures for long-term care homes (LTCHs) identified that homes must ensure the PPE requirements as set out in the "COVID-19 Guidance: LTCHs and Retirement Homes (RHs) for Public Health Units (PHUs)", or as amended, were followed.

The Ministry of Health COVID-19 Guidance Document: LTCHs identified that all staff providing direct care to or interacting within two meters of a resident with a suspect or confirmed COVID-19 or in an outbreak area should wear eye protection, gown, gloves, and a fit-tested, seal-checked N95 respirator as appropriate PPE.

The home was declared in a facility wide outbreak and subsequently received direction from the local public health unit that staff were to wear N95 masks and eye protection on all resident home areas. During the inspection, the Inspectors observed multiple staff without the required eye protection, while on resident home areas.

The Infection Prevention and Control (IPAC) lead identified that all staff were supposed to wear eye protection while on resident home areas after they received direction from the public health unit, as they were in a facility wide outbreak.

Sources: Inspector observations of staff on resident home areas; Policy titled: Additional Precautions I1-1 revised October 2022; Minister's Directive: COVID-19 response measures for LTCHs, effective August 30, 2022; COVID-19 Guidance Document for LTCHs, RHs, and Other Congregate Living Settings for PHUs

in Ontario, version 8, updated October 6, 2022; and interviews with the IPAC lead and other staff. [638]

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

1. The licensee has failed to ensure that a resident was protected from abuse by a Registered Practical Nurse (RPN).

Emotional abuse is defined within the Ontario Regulation 79/10 as 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.

During an interaction with a resident, a RPN made inappropriate comments towards a resident. The RPN acknowledged that their manner and actions were inappropriate.

Staff's actions towards the resident had a negative impact on the resident's emotional well-being at the time of the incident.

Sources: Home policy titled: Abuse, Neglect and Retaliation Prevention #05-03 (dated September 17, 2020); investigation interview notes; written warning; and interviews with the Director of Care (DOC) and other staff. [638]

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

A PSW responded to a resident in a manner that made the resident feel like they were being punished. The PSW admitted that the way they spoke to the resident was emotional abuse, and that they had not taken the proper actions required when the resident identified their need for care.

There was moderate harm to the resident when the PSW’s approach left the resident to perceive the interaction as demeaning and feeling emotionally distressed.

Sources: the resident's progress notes, care plan and Minimum Data Set (MDS), quarterly assessment; home’s policy titled, “Abuse, Neglect and Retaliation Prevention”, last revised September 17, 2020; the home’s investigation notes; the PSW's Letter of Discipline; and interviews with the resident, PSW, and the Resident and Family Navigator/Unit Manager (UM). [704609]

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 23 (1) (a) (i)

The licensee has failed to ensure that every alleged incident of abuse was immediately investigated.

A Critical Incident report was submitted to the Director regarding allegations of verbal abuse of a resident by a RPN. The report identified that a PSW had first informed the UM of the allegations of abuse prior to reporting them to another UM. Both UMs confirmed that an investigation had not occurred when the PSW first reported the allegations.

The failure of the first UM to immediately investigate the allegations of abuse, presented a potential risk of harm to the resident.

Sources: Long-Term Care Homes Portal; the home's investigation notes; the home's policies titled, "Abuse, Neglect and Retaliation Prevention", last revised September 17, 2020, and "Critical Incident System (CIS) Report", last revised June 30, 2021; and interviews with a PSW, Resident and Family Navigator/UM, the second UM, and the DOC. [704609]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2. and FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred, was immediately reported to the Director.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 24 (1) of LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 28 (1) of FLTCA.

1. During an investigation conducted by the home, it was identified that a RPN failed to provide an assessment of two residents when there was a change in their condition, which resulted in the delay of necessary medical care.

A UM indicated that not providing the required assessments was deemed by the home to be neglect. The UM and the DOC confirmed that a CI report was not submitted to the Director for either of the incidents related to neglect.

Failure to report to the Director as required, had no impact on and did not present a risk to the two residents' health, safety, or quality of life.

Sources: Long-Term Care Homes portal; the home's policies titled, "Critical Incident System (CIS) Report", revised June 30, 2021, and "Abuse, Neglect, and Retaliation Prevention, revised May 6, 2022; the residents' progress notes; the home's investigation notes; discipline letter to the RPN; and interviews with the UM and the DOC. [704609]

2. A Critical Incident report was submitted to the Director regarding allegations of verbal abuse of a resident by a RPN. The report identified that a PSW had first informed a UM of the allegations of abuse prior to reporting them to a second UM.

The second UM and the DOC verified that the home's abuse policy was not complied with when the first UM did not immediately report the allegations of abuse of the resident to the Director.

The failure of the UM to immediately report the allegations of abuse, had no impact on and did not present a risk to the resident's health, safety, or quality of life.

Sources: Long-Term Care Homes Portal; the home's investigation notes; the home's policies titled, "Abuse, Neglect and Retaliation Prevention", last revised September 17, 2020 and "Critical Incident System (CIS) Report", revised June 30, 2021; and interviews with the PSW, Resident and Family Navigator/UM, the second UM, and the DOC. [704609]

3. A PSW witnessed a RPN make inappropriate comments toward a resident. The resident reported the incident to a second RPN on a subsequent shift, which was then reported to management.

The PSW failed to immediately report potential emotional abuse as per the home's process, when they witnessed the RPN's interaction with the resident, which placed the residents at risk of abuse and led to a delay in the notification of the Director when an incident of abuse was witnessed.

Sources: Home policy titled: Abuse, Neglect and Retaliation Prevention #05-03 (dated September 17, 2020); investigation interview notes; and interviews with the DOC and other staff. [638]

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)

The licensee has failed to ensure that a resident received assistance with care as specified in their plan of care.

A PSW provided care to a resident that did not follow the resident's plan of care. The PSW and the DOC both confirmed that staff were to always follow the resident's plan of care when providing assistance with care.

There was moderate risk for harm to the resident's safety, when the PSW did not follow what was outlined in the resident's plan of care.

Sources: the resident's care plan and Minimum Data Set, Quarterly assessment; home's policy titled, "Lifts and Transfers Criteria: Policy CS L. 7 - Clinical Services" revised April 4, 2021; the home's investigation notes; and interviews with the resident, PSW and the DOC. [704609]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (3) (b)

The licensee has failed to ensure that the Responsive Behaviours program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The home's policy titled, "Responsive Behaviours, Combative Behaviours", was last revised August 4, 2021. The DOC acknowledged that the home's Responsive Behaviours program had not been evaluated in 2022.

There was low risk to the residents, when the home failed to ensure that at least annually, the Responsive Behaviours program was evaluated and updated.

Sources: Home's policy titled, "Responsive Behaviours, Combative Behaviours, CS-R.5, last revised August 4, 2021; and interviews with the DOC and other staff. [704609]