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: June 27, 2023	
Inspection Number: 2023-1535-0003	
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 Jennifer Lauricella (542)	**Inspector Digital Signature** Jennifer Lauricella Digitally signed by Jennifer Lauricella Date: 2023.07.04 16:22:16 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 23, 24, 25, 2023.

The following intake(s) were inspected:

- One intake related to, an incident that resulted in an injury to a resident.

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

Safe and Secure Home
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres.

An interview with a PSW had indicated that the window in a resident's room had not had the small blocks of wood secured to the window frame (to prevent it from opening past 15 centimetres) since the resident had been admitted to that room.

An interview with the Maintenance Manager was completed in which they indicated that when as assessment of the room was conducted, there were no blocks of wood in the window or in the room.

There was actual risk to the resident as their window opened more than 15 centimetres.

Sources: Critical Incident (CI) report ; health care records; home's investigation file and interviews with staff.

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WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (a)

The licensee has failed to ensure that before discharging a resident, that alternatives to discharge had been considered and, where appropriate, tried.

A review of the progress notes was conducted on PointClickCare (PCC) and the home's discharge documentation. It was documented in the progress notes that the resident returned to the home, however, was transferred back to the hospital. The home's Resident and Family Navigator documented in the progress notes, that they communicated with the hospital and informed them that the home was preparing to discharge the resident.

An interview with the home's Resident and Family Navigator concluded that the home discharged the resident without considering alternatives as they felt that they were unable to safely care for the resident.

SOURCES: CI report; the residents health care record file; hospital documentation regarding discharge and interview with the Resident and Family Navigator for the home.

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WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (d)

The licensee has failed to ensure that before discharging a resident, they provided a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they related to both the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge the resident.

The discharge letter was reviewed, which did not contain any information that set out a detailed explanation of the supporting facts to justify the licensee's decision to discharge the resident.

An interview with the home's Resident and Family Navigator concluded that the discharge letter did not contain all of the requirements under the legislation.

SOURCES: CI report; discharge letter and interview with staff.

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