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
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: August 9, 2023	
Inspection Number: 2023-1535-0004	
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 Nicholls (691)	**Inspector Digital Signature** Jennifer J Nicholls Digitally signed by Jennifer J Nicholls Date: 2023.09.06 10:08:48 -04'00'
Additional Inspector(s) Christopher Amonson (721027) Shelley Murphy (684)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 26- 30, 2023.

The following intakes were completed during this inspection:

- Two Intakes related to missing controlled substance;
- One Intake related to an allegation of Neglect to a resident;
- One Intake related to an allegation of physical abuse of a resident;
- Two Intakes related to falls;
- One Intake related to Improper/incompetent care of resident;

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

Resident Care and Support Services
Medication Management

Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

1) The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary

A resident's care plan had specific instructions related to the care of a resident while providing care.

During an interview with a Personal Support Worker (PSW) they stated they did not follow the care plan while completing care. The nurse manager indicated that the PSW did not provide care as per the care plan.

The risk to the resident was moderate as they sustained an injury.

Sources- Resident's care plan, the home's policy "Admission Plan of Care A6.2", staff and nurse manager interviews.
[684]

2) The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

A resident had a history of exhibiting responsive behaviors and it was identified in the resident's written plan of care specific interventions to provide care to this resident.

During an interview with the PSW and the Nurse manager, they indicated to the Inspector that they did not follow the specific interventions when they provided care to this resident, and they should have.

The risk to the resident was minimal as resident had no ill effect from the incident.

Sources-CIS report, Resident's care plan and progress notes, the home's policy "Admission Plan of Care A6.2", internal investigation package, interviews with staff and the nurse manager.
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WRITTEN NOTIFICATION: Pain not assessed
NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.

The licensee has failed to ensure that when the resident indicated they were in pain, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, and that the pain policy was complied with.

Rationale and Summary
On an identified date it was reported by staff that a resident indicated that they were in pain at a specified time. A review of the Electronic Medical Record (EMR) indicated that there was no pain assessment completed, or pain medications administered to the resident in a timely manner.

The Nurse Manager confirmed that based on the investigation, the progress notes, and assessments of the resident, they were not assessed for pain appropriately, and the pain policy was not complied with. The Registered Practical Nurse (RPN) should have assessed resident's pain immediately and administered the ordered PRN pain medication as required.

There was moderate harm to the resident, as they expressed pain.

Sources: A resident's progress notes, EMAR and assessments; licensee policy titled "Pain Management Protocols", CS, last reviewed August 4, 2021; and interviews with the Nurse Manager, and other staff.

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