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: June 14, 2024

Inspection Number: 2024-1535-0002

Inspection Type:
Other
Critical Incident

Licensee: The Board of Management for the District of Nipissing East

Long Term Care Home and City: Cassellholme, North Bay

Lead Inspector	**Inspector Digital Signature**
Samantha Fabiilli (000701)	Samantha Fabiilli Digitally signed by Samantha Fabiilli Date: 2024.07.04 16:00:26 -04'00'

Additional Inspector(s)
Melanie Northey (563)
Rhonda Kukoly (213)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 15-19, 2024 and April 22-26, 2024
The inspection occurred offsite on the following date(s): April 25 and 26, 2024

The following intake(s) were inspected:

- One intake related to missing controlled substance,
- Six intakes related to abuse,
- Two intakes related to neglect,
- One intake related to improper/incompetent care,
- One intake related to falls,
- One intake related to emergency plan attestation.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
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 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the residents.

Rationale and Summary
A review of a resident's care plan identified an inaccurate intervention related to responsive behaviours. A staff member confirmed that this intervention in the

resident's care plan was inaccurate.

Multiple resident's care plans were reviewed for accuracy, in which this review verified the care plans were not customized with specific focus statements, and interventions based on an assessment.

Sources: resident clinical record reviews, CIS reports and staff interviews.
[563]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has 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
An incident occurred while staff were providing care to a resident. It was identified that staff were not providing the level of assistance required for this care, as outlined in the plan of care. This was confirmed by staff and the DOC of the home.

There was risk to this resident as a result of not providing care as specified in the plan.

Sources: Critical Incident Report, health records for a resident and staff interviews.

[213]

WRITTEN NOTIFICATION: Plan of care - Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Rationale and Summary:
During information gathering related to an incident involving a resident, it was identified that care was provided to this resident, however, was not documented. The DOC confirmed that there was no documentation in relation to this provision of care.

There was low risk to the resident as a result of not documenting this care.

Sources: A resident's health records; Home's investigation file; Home's policy; A resident's progress notes; Interviews with staff and DOC.
[000701]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

The licensee has failed to ensure that improper care of a resident, which resulted in harm, was immediately reported.

Rationale and Summary
Regarding an incident that occurred on a specified day, a staff member indicated that they were not aware this incident was to be immediately reported to the Director.

Sources: A Critical Incident Report, health records for a resident and staff interviews. [213]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when

assisting a resident.

Rationale and Summary:
In review of an incident that occurred, it was identified that staff did not follow the interventions, outlined in a resident's plan of care, when transferring the resident.

Staff confirmed that this resident was not transferred as per the requirements in their care plan.

Not using safe transferring techniques, as outlined in the resident's care plan, when transferring, placed the resident at moderate risk.

Sources: A resident's care plan; Home's investigation file; Home's policy; Interviews with staff.
[000701]

WRITTEN NOTIFICATION: Required programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,
(b) provide for assessment and reassessment instruments. O. Reg. 246/22, s. 53 (2).

The licensee has failed to ensure that an assessment, as part of a required program of the home, was completed in relation to an incident.

Rationale and Summary

Upon reviewing an assessment it was identified that the assessment was not completed in full. A staff member confirmed that the assessment should have been completed but was not. The DOC also confirmed this assessment should have been completed as part of the related program.

There was risk to the resident as a result of not completing the assessment in full.

Sources: A Critical Incident Report; Policies of the home; A resident's health records; and Staff interviews. [213]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee has failed to ensure that a resident received assistance from staff to manage and maintain continence.

Rationale and Summary:
A resident's care plan outlined interventions for required assistance. However, in review of investigation notes, it was identified that the resident did not receive the required assistance when requesting help.

There was moderate impact to the resident as a result of not receiving the required

assistance.

Sources: A resident's care plan; The homes Investigation file and notes; Interviews with a resident and staff.
[000701]

WRITTEN NOTIFICATION: Attestation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 270 (3)
Attestation
s. 270 (3) The licensee shall ensure that the attestation is submitted annually to the Director.

The licensee has failed to ensure that they completed the emergency plan attestation annually and submitted to the Director.

Rationale and Summary:
The Administrator indicated that the home had emergency plans in place, but was not aware that the attestation needed to be signed and submitted annually. They could not find a signed attestation for 2023.

The Administrator later provided inspector with a copy of the signed attestation.

There was low risk to residents as a result of not signing the 2023 Emergency Plan Attestation.

Sources: Interview with the Administrator: Signed Attestation.
[000701]

COMPLIANCE ORDER CO #001 Duty to protect

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Review and revise, as needed, the home's policy related to responsive behaviours and all associated worksheets and appendices. A documented record of the review, the changes made if any, and who participated must be maintained.
2. Ensure specified staff of the home review the process and implementation and scheduling of one on one staff. A documented record of the review, the changes made if any, and who participated must be maintained.
3. Retrain specified staff on prevention of abuse and neglect. Keep a written record of the training, specifically, date completed and the contents of the training.
4. Retrain specified staff on documentation, specifically the importance of accurately documenting provision of care. Keep a written record of the training, specifically, date of completion and the contents of the training.
5. Complete weekly audits, for a minimum of four weeks, on a resident's scheduled specified task and, as per their plan of care, to ensure completion. Keep a written record of the audits including the findings of each audit, concerns identified, and any corrective action taken.
6. Retrain specified staff on the home's policy for assessing, reporting and monitoring resident skin concerns. Keep a written record of the training, specifically, date of completion for each staff and the contents of the training.

Grounds

The licensee failed to protect residents from abuse by a fellow resident, as well as abuse and neglect by staff.

1)
Rationale and Summary
Incidents of resident to resident abuse occurred on specified dates. However, there were gaps in the documentation which prevented the home from following up on the incidents.

As well, on another specified date, it was identified that there was no monitoring intervention in place to prevent further incidents with a specified resident.

There was risk to residents as a result of the home not fulfilling their duty to protect.

Sources: A resident clinical record reviews, Clinical - Incident Reports, Assessment worksheets and staff interviews.
[563]

2)
Rationale and Summary:
An allegation of abuse occurred on a specified date, between a staff and resident.

Management of the home both confirmed the abuse was substantiated and the staff involved was disciplined.

Not protecting a resident from abuse posed a moderate risk to the resident.

Sources: Review of the homes investigation file; Home's policy; and interviews with management.
[000701]

3)
Rationale and Summary:
An allegation of abuse occurred on a specified date, between a staff and a resident.

Management of the home confirmed the abuse was substantiated.

Not protecting a resident from abuse posed a moderate risk to the resident.

Sources: Interview with management; Review of the home's investigation file; and Home's policy.
[000701]

4)
Rationale and Summary:
An allegation of neglect occurred on a specified date.

In review of a resident's care plan, specified interventions of resident care were identified. However, although the care was signed off as being completed, there was evidence to suggest this did not occur.

Management of the home confirmed that the neglect was substantiated.

There was moderate risk and moderate impact to a resident as a result of the substantiated neglect.

Sources: A resident's care plan; A resident's health records; The home's investigation file; Interviews with staff.
[000701]

This order must be complied with by August 9, 2024

COMPLIANCE ORDER CO #002 Reporting certain matters to Director

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:
a) Ensure all specified staff receive training/education related to FLTCA s. 28 (1) 2.
b) Training must include the types of abuse, grounds to suspect that abuse may occur and of risk of harm.
c) A documented record must be maintained of this training, including the date the training was provided, content covered as part of the training, who provided the training, and who attended the training.

Grounds
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 the licensee or staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director

1) Rationale and Summary
Multiple incidents of potential resident abuse were identified through the documentation in resident charts. However, these incident's were either not reported or not immediately reported to the Director.

There was an increased risk to residents when the home failed to report the allegation to the Director.

Sources: resident clinical record reviews, Clinical - Incident Reports, and staff interviews.
[563]

2) Rationale and Summary:
Critical Incident reports were submitted which indicated that incidents of abuse occurred, however these incidents were not reported to the Director immediately.

Management of the home confirmed that this incident should have been reported immediately.

Not reporting the incident immediately to the Director resulted in a low risk to the resident.

Sources: Critical Incident Reports; Interview with management.

[000701]

This order must be complied with by August 9, 2024

COMPLIANCE ORDER CO #003 Altercations and other interactions between residents

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must:
a) Ensure that for specific residents who were demonstrating responsive behaviours; the behavioural triggers for the resident are identified, appropriate strategies are developed and implemented to respond to behaviours, and the actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions are documented.
b) Ensure those residents affected by the behaviours of specified resident's have appropriate individualized strategies developed and implemented to protect them.
c) Conduct an audit to ensure the plan of care for specified residents and any other

residents affected by these behaviours provides, at minimum, the strategies and care they require related to responsive behaviours. A documented record must be maintained of this audit, including the date the audit was completed, who completed the audit, the name of the resident the audit was completed for, any concerns identified, and the corrective action taken as a result of the audit. The auditing process is required for a minimum of four weeks.

Grounds
The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identifying and implementing interventions.

1.
Rationale and Summary
Incidents occurred involving resident to resident abuse. However there were no documented interventions as part of a resident's care plan that identified triggers or any specific strategies to minimize the risk of potentially harmful interactions.

Sources: resident clinical record reviews, Clinical - Incident Reports, policies and staff interviews.
[563]

2.
Rationale and Summary
Assessments completed for specified dates, for a resident, identified new behaviours but there was no documentation completed related to this assessment.

Furthermore, related interventions in a resident's care plan were vague and not specific. The Director of Care (DOC) verified the intervention was vague and did not provide specific information.

Also, there were no specific interventions implemented as part of the care plans of other resident's involved, to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between them.

Sources: resident clinical record reviews, Clinical - Incident Reports, Assessments and staff interviews.
[563]

This order must be complied with by **August 9, 2024**

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.