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 2, 2024
Inspection Number: 2024-1535-0003
Inspection Type: Complaint Critical Incident
Licensee: The Board of Management for the District of Nipissing East
Long Term Care Home and City: Cassellholme, North Bay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 15-19, 2024.

The following intake(s) were inspected:

- One intake, related to a complaint submitted regarding concerns with pain management of a resident; and
- Three intakes, related to abuse of resident by another resident, resulting in injury.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain 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)
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 a resident's plan of care was provided to the resident, as specified in the plan.

Rationale and Summary:
A complaint had been submitted regarding the pain management for a resident. The complainant indicated that the resident had a medical intervention, and it was recommended that a specified assistive device was to be put in place; however, it had not been implemented.

The resident's plan of care identified that the specified assistive device was implemented on an identified date. The Inspector observed on two consecutive dates that the specified assistive device was not in place. Further observations identified the specified assistive device had been implemented for the resident on the second day of observation.

Direct care staff, registered staff, and the Director of Care (DOC) all identified that

staff were to follow the direction that was in the resident's plan of care. They all indicated that the resident's plan of care had been updated to include the implementation of the specified assistive device; however, it had not been implemented until a number of days after the plan of care had been updated.

There was a low risk to the resident, as they had not sustained any ill effects by staff not providing the care as specified in the plan.

Sources: complaint log; a resident's health care records; Inspector's observations; and interviews with direct care staff, registered staff, and the DOC.

Date Remedy Implemented: July 16, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident, collaborated with each other in the development and implementation of the plan of care, so that the different aspects of care were integrated and were consistent with, and complemented each other.

Rationale and Summary
A resident had been exhibiting pain to a specific area of their body, and the physician had ordered specific diagnostic testing in order to determine a diagnosis and implement the appropriate treatment.

The physician had ordered three different diagnostic tests to be completed as soon as possible for the resident on three separate dates. Progress notes and the diagnostic test requisitions identified that the first order was not processed until 14 days after the physician ordered them, the second eight days later, and the third wasn't processed until two days later.

Registered staff indicated that all physician orders were to be processed at the time the orders were written. They identified that by not processing the physician orders for the resident when written it would delay the diagnostic testing being completed, which could cause a delay in providing the appropriate medical interventions. The DOC identified that it was the homes process for registered staff to process the physician orders right away and confirmed that the registered should have sent the requisitions / referrals when ordered by the physician.

There was risk to the resident when there was a delay in processing the physician orders, which resulted in a delay of the diagnostic tests being completed and implementing medical treatment.

Sources: complaint log; a resident's health care records, including physician orders, assessments, and consultations; and interviews with complainant, registered staff, and the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that an allegation of two incidents of resident-to-resident abuse by a resident, were reported to the Director immediately.

Rationale and Summary
(a) On an identified date, it had been observed that a resident had exhibited a specified responsive behaviour towards another resident. The CI report was not submitted by the Long-Term Care Home (LTCH) until the following day, and there had not been an after-hours call submitted.

(b) There was an incident of resident-to-resident responsive behaviours reported to the RN charge nurse; the CI report was not submitted until the next day. The LTCH had not reported the incident to the Director immediately.

Registered staff and the DOC identified that all allegations of abuse towards a resident, by anyone, were to be immediately reported to the Director, and confirmed both incidents of responsive behaviours by a resident towards another resident were not.

There was low risk to the residents for not immediately reporting the allegations to

the Director.

Sources: Two CI reports; three residents health care records; the LTCHs internal CI reports; the LTCHs policy, titled "Abuse, Neglect and Retaliation Prevention", #05-03, last reviewed May 2, 2024; and interviews with registered staff, and the DOC.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that for a resident, that the behavioural triggers were identified, that strategies were developed and implemented to respond to responsive behaviours, and actions were taken in response to the resident's needs, and the resident's responses to interventions were documented.

Rationale and Summary
There were two CI reports submitted for a resident exhibiting a specific responsive behaviour towards another resident. In both incidents, the resident exhibiting the responsive behaviour indicated it was due to the responsive behaviour the other

resident had been exhibiting. The CI report and progress notes also identified that there had been multiple incidents where the resident had exhibited the same responsive behaviour to the same resident. As well, that a specified monitoring process was to be completed on the resident following the incidents.

Direct care staff and registered staff had identified that the resident had a history of responsive behaviours. They all indicated that the responsive behaviours exhibited by the resident were triggers for the other resident to exhibit responsive behaviours.

(a) The resident's plan of care was reviewed and was unable to locate a focus to identify the specified responsive behaviour. As well, it did not indicate that their responsive behaviours were triggers for the identified resident to exhibit responsive behaviours. There were not any strategies or interventions implemented to mitigate the risk to the resident.

(b) The specified monitoring process was reviewed for the dates indicated, it revealed that there had been two entire shifts incomplete. Direct care staff and registered staff confirmed that once the specified monitoring process was initiated, it was to be completed in its entirety, and it was not for the resident.

The DOC identified that the resident's plan of care should have included that they exhibited responsive behaviours and that those behaviours were a trigger for another resident. They indicated that there should have been interventions put in place for staff to be aware and implement, to be able to manage the resident's responsive behaviours and mitigate risk to other residents.

There was an impact and risk towards the resident, for the LTCH not identifying the residents' responsive behaviours and potential risk for resident-to-resident altercations.

Sources: Two CI reports; a resident's health care records; the LTCHs internal investigation and CIs; the LTCHs policy titled, "Responsive Behaviours: Resident Altercations and Safety Precautions", #CS-R.4, last revised August 4, 2021; and interviews with a resident #002, direct care staff, registered staff, and the DOC.