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

Public Report

Report Issue Date: December 16, 2025
Inspection Number: 2025-1535-0005
Inspection Type: 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): December 8 to 12, 2025

The following intake(s) were inspected:

- One intake related to an alleged abuse of a resident by another resident;
- One intake related to a fall incident of a resident that resulted in an injury;
- One intake related to an alleged abuse of a resident by a staff member;
- One intake related to a fall incident and unexpected death of a resident, and
- One intake related to an alleged care neglect of a resident by staff members.

This CI Inspection was conducted concurrently with a Post Occupancy Follow-up Inspection #2025_1535_0006.

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

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident's Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

A staff member had transferred a resident despite their multiple requests to remain in bed and physically pulled on the resident to assist them out of bed.

Sources: A CI report, review of the home's investigation notes; interviews with the resident and PSW; review of the resident's electronic records, and an interview with a Nurse Manager.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #002 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;

A resident required assistance for their continence care on a specified date. Due to shift change of staff members, continence care equipment was left under the resident for a specific period of time causing discomfort.

Sources: A CI report; resident observation; review of the resident clinical records; review of the home's policy; interview with staff members and the DOC.

WRITTEN NOTIFICATION: Notification of Police

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

A resident had reported an allegation of abuse by a staff member. As per the home's policy, the police were supposed to be notified, but they were not.

Sources: A CI report; review of the home's investigation notes; interview with the resident and staff; review of the resident's electronic records, and an interview with a Nurse Manager.

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 2.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on their assessed needs.

A CI was reported by the home related to a substantiated care neglect of a resident by staff members. Both staff were supposed to be retrained for a specific policy immediately, but this did not occur.

Sources: A CI report; resident observation; review of resident's clinical records; review of the home's policy; interview with staff members, the Clinical Quality Manager, and the DOC.

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