

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: March 3, 2026

Inspection Number: 2026-1535-0002

Inspection Type:

Complaint
Critical Incident
Follow up

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): February 23-27, 2026.

The following intake(s) were inspected:

- One intake related to Improper/incompetent care of a resident;
- One intake related to an incident that resulted in a change of resident condition;
- One intake (Follow-up #: 1 -CO #001/2025-1575-0006, O. Reg. 246/22 - s. 12 (1) 1. iii. - Doors in home;
- One intake related to resident to resident physical abuse;
- Two intakes related to neglect of a resident; and,
- One intake related to a resident care complaint.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1535-0006 related to O. Reg. 246/22, s. 12 (1) 1. iii.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Safe and Secure Home
Responsive Behaviours

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Prevention of Abuse and Neglect

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)

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.

a) On a specified day a resident's care was not completed as identified in the resident's plan of care.

Source: Resident's electronic health records; Internal investigation notes; and staff interviews.

b) On a specific day, it was reported that the care a resident required had not been completed. Staff acknowledged that the required care for the resident was missed.

Sources: Resident's electronic health records; Internal investigation notes; and staff interviews.

WRITTEN NOTIFICATION: Complaints Procedure

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

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During an interview with staff they confirmed receiving care concerns for a resident on a specified date, and acknowledged that they did not immediately forward this to the Director.

Sources: Review of the care concerns, the home's policy, and staff interviews.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 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.

A resident received improper care on a specified date, this was not immediately reported to the Director.

Sources: Critical incident(CI); the home's investigation notes; Review of the resident's clinical records; Review of the home's policies; Review of the home's internal investigation notes; and staff interviews.

WRITTEN NOTIFICATION: Care Conference

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

Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)

Care conference

s. 30 (1) Every licensee of a long-term care home shall ensure that,

(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

A resident was admitted, and did not receive a six week care conference.

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Sources: Clinical record review, the home's policy, and staff interviews.

WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (2)

Pain management

s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

On a specified date a staff member failed to conduct an assessment as required.

Sources: Clinical record review, investigation file, CI report, the home's policy, and staff interviews.

COMPLIANCE ORDER CO #001 Skin and wound care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

- a) Educate front line staff who provide care to a specific resident, on their plan of care.
- b) Re-educate specific staff on the home's process related to altered skin integrity.
- c) Keep a documented record of when the training occurred, who provided the training, who completed the training and the contents of the training.

Grounds

- a) A staff member failed to notify registered staff when a resident was noted to have

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altered skin integrity.

b) On two separate days a resident did not receive care as per their plan of care interventions.

Sources: Critical Incident, resident progress notes, care plan, assessments, observations on two separate days, the home's policies and staff interviews.

This order must be complied with by April 27, 2026

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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

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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.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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