Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2014	2014_283544_0011	S-000136, 146, 145-14	Critical Incident System

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST
400 Olive St., NORTH BAY, ON, P1B-6J4

Long-Term Care Home/Foyer de soins de longue durée

CASSELLHOLME
400 OLIVE STREET, NORTH BAY, ON, P1B-6J4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

FRANCA MCMILLAN (544)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 10, 11, 2014 and was related to:

Log # S-000146-14
Log # S-000136-14
Log # S-000145-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, RAI/MDS Co-ordinator, Nursing Supervisors, Manager of Human Resources, Registered Staff, PSWs, Resident and Families.

During the course of the inspection, the inspector(s) walked through-out the home daily in particular to ensure doors were locked in specific areas where residents may enter, observed daily the care and service delivery to the residents, observed daily the residents exhibiting Responsive Behaviours, the daily staff to resident interactions, reviewed the Prevention of Abuse and Neglect Policy and the staff education regarding the Prevention of Abuse and Neglect Policy, reviewed the Locked Doors Policy, reviewed the Responsive Behaviours Program and staff education records regarding the Responsive Behaviours Program, reviewed the resident's health care records, care plans and RAI/MDS assessments.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from Abuse and Neglect by Staff # 200 as shown by the following:

1. According to a Critical Incident, an allegation of resident abuse by Staff # 200 was reported to Management of the home in two (2) separate written statements, by two

(2) witnesses in March 2014. Both incidents occurred in March 2014.
• According to the first written statement, a witness reported to management, abuse and neglect when Staff # 200 addressed a resident in a "quick and abrupt manner". The resident asked Staff # 200 to have their teeth cleaned before being toileted. Staff # 200 responded, "Why don't you stop complaining about the things we don't do for you and be happy for the things we actually do for you?" While Staff # 200 continued to provide personal care to the resident, Staff # 200 told the witness how rude this resident is. Staff # 200 did not follow the resident's request to have their teeth brushed.
• This incident resulted in Staff # 200 receiving a 3 day suspension.

• According to the second written statement, in the same Critical Incident, another witness, reported to management, abuse and neglect by Staff # 200 when providing care to a resident. The resident was in bed and the manner in which Staff # 200 dealt with the resident was described as "rough and careless." It was reported that staff # 200 said, "I would call you migraine because you give me one." "For the love of God, can you just listen? You have a brief, so go in it." In the presence of the resident, Staff #200 stated the need to be paid double for looking after the resident.
• This incident resulted in Staff # 200 receiving a 5 day suspension.

2. Inspector # 544 reviewed the personnel file for Staff # 200 and noted documentation pertaining to the following:

• Allegations of abuse and neglect of residents by Staff # 200 in three separate incidents that occurred over three consecutive months in 2013.
• In April 2013, a complaint was received by management of the home, from a third party concerning an offensive odour from a resident that Staff # 200 was responsible to bathe.
• In May 2013, a resident complained about the treatment that was received from Staff #200 when ringing the call bell. The resident was upset and crying as a result of the manner in which staff # 200 spoke. Staff # 200 was verbally counselled by the Nursing Supervisor.
• In June 2013, two staff members complained about the care of a resident and about the manner in which Staff # 200 spoke to a resident. Staff # 200 became angry and "yelled" at the resident. In another incident, Staff # 200 chose to go to a supper break before caring for a resident who required assistance. Care was provided to this resident by another staff member. These episodes demonstrated neglect and anger when Staff # 200 spoke to residents in a raised voice.

• The incidents above occurred despite Staff # 200 having attended the Gentle Persuasion Approach (GPA) Workshop the previous year.

• Staff # 200 received verbal counselling and a written warning letter for these three (3) separate incidents of abuse and neglect occurring in 2013.

3. Inspector # 544 reviewed the Home's Progressive Discipline Policy, Policy# 07-34 which outlines:

(1) Verbal warning, counselling session
(2) Written warning
(3) One (1) day suspension without pay
(4) Three (3) day suspension without pay
(5) Termination of the employee.

4. Inspector # 544 spoke with Staff # 107, via telephone in April 2014.

•Staff # 107 confirmed that Staff # 200 was hired in 2012 and the probationary period for some staff designation is 400 hours.

• Inspector # 544 reviewed the Probationary/Interim Review for Staff # 200, that was conducted by Staff # 101. This review identified that Staff # 200 required improvement in all areas of work.

As a result of this Probationary/Interim Review, the probationary period for Staff # 200, was extended for another three months. A secondary review was to take place November 2012.

It was confirmed by Staff # 107 that a secondary review was not completed and did not occur as scheduled.

A verbal warning was provided to Staff # 200 by management in a meeting in July 2013 for three (3) incidents of abuse and neglect of residents. At the same time, staff # 200 received a written letter of warning relating to the same three (3) incidents.
In April 2014, staff # 200 received two (2) further letters related to incidents of abuse and neglect of residents, suspending staff # 200 for a total of eight (8) days from work.

Since April 2013, there has been a progressive pattern of verbal abuse and neglectful conduct on the part of Staff # 200 culminating in an eight (8) day suspension from work in March and April 2014.
This pattern of abuse and neglect since April 2013, demonstrates the licensee's failure to protect the residents.

The licensee of the long-term care home did not protect residents from abuse by Staff #200 and did not ensure that the residents are not neglected by staff. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. Inspector observed when closing the door of a Nursing Supervisor's office, it was sticking and required an extra push to ensure the door closed fully and locked. Staff # 105 confirmed that the door to the office was not locked or closed fully when the office was left. Resident # 003 was able to enter the office and the door then locked. The door was opened by the Nursing Supervisor with the key and Resident # 003 was then led out of the office.
It was confirmed by Staff # 105, that the door to the office was not locked upon leaving the office.
The licensee of the home failed to ensure that all doors leading to non-residential areas must be kept closed and locked when they are not being supervised by staff, to restrict unsupervised access to these areas by residents. [s. 9. (1) 2.]

Issued on this 1st day of May, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

#544

Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8	Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	FRANCA MCMILLAN (544)
Inspection No. / No de l'inspection :	2014_283544_0011
Log No. / Registre no:	S-000136, 146, 145-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 1, 2014
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST 400 Olive St., NORTH BAY, ON, P1B-6J4
LTC Home / Foyer de SLD :	CASSELLHOLME 400 OLIVE STREET, NORTH BAY, ON, P1B-6J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BRENDA LOUBERT

To BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that residents are protected from abuse and neglect by all staff, in particular Staff # 200 and that it's Human Resource practices support compliance with the duty to protect.

Grounds / Motifs :

1. The licensee failed to protect residents from Abuse and Neglect by Staff # 200 as shown by the following:
1. According to a Critical Incident, an allegation of resident abuse by Staff # 200 was reported to Management of the home in two (2) separate written statements, by two (2) switnesses in March 2014. Both incidents occurred in March 2014.

.• According to the first written statement, a witness reported to management, abuse and neglect when Staff # 200 addressed a resident in a “quick and abrupt manner”. The resident asked Staff # 200 to brush their teeth before being toileted. Staff # 200 responded, “Why don't you stop complaining about the things we don't do for you and be happy for the things we actually do for you?” While Staff # 200 continued to provide personal care to the resident, telling the witness how rude this resident is. Staff # 200 did not follow the resident's request to have their teeth brushed.

• This incident resulted in Staff # 200 receiving a 3 day suspension in March 2014, as identified in a letter on file dated on April 2014

• According to the second written statement, in the same CI, on the same day, another witness reported to management, abuse and neglect by Staff # 200 when providing care to a resident. The resident was required toileting and the

manner in which Staff # 200 dealt with the resident was described as "rough and careless." It was reported that staff # 200 said, "I would call you migraine because you give me one." "For the love of God, can you just listen? You have a brief, so go in it." In the presence of the resident, Staff #200 stated that payment for working, should be doubled for looking after the resident.

• This incident resulted in Staff # 200 receiving a 5 day suspension in April 2014.

2. Inspector # 544 reviewed the personnel file for Staff # 200 and noted documentation pertaining to the following:

• Allegations of abuse and neglect of residents by Staff # 200 in three separate incidents that occurred over three consecutive months in 2013.

• In April 2013, a complaint was received by management of the home, from a third party concerning an offensive odour from a resident that Staff # 200 was responsible to bathe.

• In May 2013, a resident complained about the treatment received from Staff # 200 when the call bell was pressed. The resident was upset and crying as a result of the manner in which staff # 200 spoke. Staff # 200 was verbally counselled by the Nursing Supervisor.

• In June 2013, two staff members complained about the care of a resident and about the manner in which Staff # 200 spoke to a resident. Staff # 200 became angry and "yelled" at a resident. In another incident, Staff # 200 chose to take a supper break before caring for a resident who required assistance. Care was provided to this resident by another staff member. These episodes demonstrated neglect and anger when staff # 200 spoke to the residents in a raised voice.

• The incidents above occurred despite Staff # 200 having attended the Gentle Persuasion Approach (GPA) Workshop the previous year.

• Staff # 200 received verbal counselling and a written warning letter in 2013 for these three (3) separate incidents of abuse and neglect occurring.

3. Inspector # 544 reviewed the Home's Progressive Discipline Policy, Policy# 07-34 which outlines:

(1) Verbal warning, counselling session
(2) Written warning
(3) One (1) day suspension without pay
(4) Three (3) day suspension without pay
(5) Termination of the employee.

4. Inspector # 544 spoke with Staff # 107, via telephone in April 2014.

•Staff # 107 confirmed that Staff # 200 was hired in 2012 and the probationary period for a classification of staff is 400 hours.

• Inspector # 544 reviewed the Probationary/Interim Review for Staff # 200, conducted in 2012 by Staff # 101. This review identified that Staff # 200 required improvement in all areas of work.

As a result of this Probationary/Interim Review, the probationary period for Staff # 200, was extended for another three months. A secondary review was to take place in November 2012.
It was confirmed by Staff # 107 that a secondary review for Staff # 200 was not completed and did not occur as scheduled.

A verbal warning was provided to Staff # 200 by management in a meeting in July 2013 for three (3) incidents of abuse and neglect of residents. At the same time, staff # 200 received a written letter of warning relating to the same three (3) incidents.
In April 2014, staff # 200 received two (2) further letters related to incidents of abuse and neglect of residents, suspending staff # 200 for a total of eight (8) days from work.
Since 2013, there has been a progressive pattern of verbal abuse and neglectful conduct on the part of Staff # 200 culminating in an eight (8) day suspension from work in March and April 2014.
This pattern of abuse and neglect since April 2013, demonstrates the licensee's failure to protect the residents.

The licensee of the long-term care home did not protect residents from abuse by Staff # 200 and did not ensure that the residents are not neglected by staff. 2007, c 8, s. 19 (1).
(544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 09, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 1st day of May, 2014

Signature of Inspector / Signature de l'inspecteur : Franca McMillan #544

Name of Inspector / Nom de l'inspecteur : Franca McMillan

Service Area Office / Bureau régional de services : Sudbury Service Area Office