Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 2, 2020	2019_805638_0030	021921-19	Complaint

Licensee/Titulaire de permis

The Board of Management for the District of Nipissing East
400 Olive Street 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

RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 16 - 20, 2019.

The following intake was inspected during this Complaint inspection;
-One log was a complaint submitted to the Director which was related to care concerns as well as staff and resident interactions with resident #001.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Clinical Services (DOC), Unit Coordinator, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and their family.

The Inspector also conducted tours of the resident care areas, observed the provision of care and services to the residents, staff to resident interactions, meal services, medication administration practices, infection prevention and control practices and the implementation of care interventions, reviewed relevant home processes, resident health care records and resident incidents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care updated when the resident's care needs changed or the care set out in the plan was no longer necessary.

A complaint was submitted to the Director which outlined concerns related to resident #001's care and alleged incidents of abuse and neglect.

Inspector #638 reviewed resident #001's health care records and identified in the resident's care plan under the foci related to their risk of falls that the resident required two specific interventions implemented.

The Inspector made observations of resident #001's room on three dates. During each observation the Inspector was unable to identify either of the two specific interventions implemented for resident #001.

In an interview with Inspector #638, PSW #101, PSW #102 and PSW #103 each indicated that they referred to the resident's electronic care plan and Kardex for resident specific care and interventions.

During an interview with Inspector #638, RPN #105 indicated that direct care staff referred to the resident's care plan for resident information. The RPN indicated that typically night shift registered staff updated the plan of care when care needs changed.

Inspector #638 interviewed the Unit Coordinator who indicated that a RN would typically update the resident's plan of care when their needs changed. The Inspector and Unit Coordinator reviewed resident #001's care plan and identified the two specific interventions. The Unit Coordinator and Inspector observed resident #001's room together and identified that neither of these interventions were implemented and they indicated they would follow up with the Inspector to determine if the care plan had to be updated or if the interventions had to still be implemented.

In a follow up interview with the Inspector, the Unit Coordinator indicated that the interventions were discontinued; however, staff had not gone back to the care plan and removed the two interventions.

In an interview with Inspector #638, the DOC indicated that whenever care needs

changed the home’s practice was that registered staff should have been updating the care plan. The DOC stated that the same would apply whenever an intervention was discontinued. The DOC indicated that the interventions were discontinued and there could have been an oversight with the care plan identifying the two specific interventions. [s. 6. (10) (b)]

Issued on this 7th day of January, 2020

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

Original report signed by the inspector.