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
Feb 25, 2020	2020_782736_0006	002611-20	Critical Incident System

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

AMANDA BELANGER (736), KEARA CRONIN (759)

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): February 18-21, 2020.

During the course of this inspection, the following log was inspected:
-one log, related to an allegation of visitor to resident abuse.

A Complaint Inspection #2020_782736_0005 was conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance of a Voluntary Plan of Correction (VPC) related to s. 24 (1) of the LTCHA 2007, was identified in this inspection and has been issued in Inspection Report, #2020_782736_0005, dated February 25, 2020, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), acting Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), private care workers and residents.

During the course of the inspection, the Inspector(s) reviewed internal investigation notes, relevant resident health care records, licensee policies, and observed the provisions of care.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s policy to promote zero tolerance of abuse was complied with.

A Critical Incident (CI) report was submitted to the Director related to an allegation of resident abuse. The CI report indicated that a private care worker had informed staff within the home that resident #001 may have been abused by a visitor.

Inspector #736 reviewed the home’s internal investigation notes, which indicated that on a specified date, Personal Support Worker (PSW) #105 had a conversation with private care worker #104, who had indicated to the PSW that they thought a visitor may have abused resident #001. The internal investigation notes further indicated that PSW #105 did not bring forward the allegations of resident abuse to a supervisor until the next day.

In an interview with PSW #105, they indicated to Inspector #736 that on the specified date, they had entered resident #001’s room and private care worker #104 engaged them in a conversation related to a visitor. PSW #105 further indicated to the Inspector that the private care worker had indicated that a visitor may have been physically abusing resident #001. PSW #105 told the Inspector that after the conversation, they had left the home without reporting the conversation to anyone, as they were not sure what to do with the information provided. The PSW also told the Inspector that they told an Registered Nurse (RN) supervisor of the conversation the next day.

In an interview with RN #107, they indicated to Inspector #736 that PSW #105 had brought forward a concern of resident abuse towards resident #001 the day after the PSW had a conversation with a private care worker. The RN indicated to the Inspector that they had confirmed with the PSW at the time of the conversation on the specific date, that the allegations had not been brought forward to anyone the day prior.

A review of the licensee’s policy titled “Abuse, Neglect and Retaliation Prevention”, #05-03, last revised July 25, 2019, directed staff that any time there was a complaint of alleged abuse or neglect, it was to be reported to a supervisor immediately.

In separate interviews with Unit Coordinator (UC) #103 and the Acting Director of Care (DOC), they both indicated to Inspector #736 that any time there was an allegation of resident abuse, the staff member who received the allegation was to immediately inform a supervisor in the building. Both the UC and Acting DOC indicated that PSW #105 had not immediately informed a supervisor of an allegation of abuse towards resident #001, when the PSW became aware, and therefore, the PSW had not complied with the

home’s policy for abuse prevention. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff comply with the home's zero tolerance of abuse policy, to be implemented voluntarily.

Issued on this 25th day of February, 2020

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

Original report signed by the inspector.