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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Aug 6, 2020	2020_841679_0008	012419-20, 014844-20	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

MICHELLE BERARDI (679), STEPHANIE DONI (681)

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): July 20-24, 2020.

The following intakes were inspected upon during this Complaint Inspection:

- Two complaints that were submitted to the Director regarding resident care concerns.

A Critical Incident System Inspection (2020_841679_0009) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Clinical Services, Support Services Manager, Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) RPN, BSO Care Support, Personal Support Workers (PSWs), Housekeepers, Residents and families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration

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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

A complaint was submitted to the Director regarding the care of resident #008. The complaint identified that resident #008 had sustained falls and was diagnosed with a specified injury.

Inspector #679 reviewed a progress note written by Registered Nurse (RN) #122 on a specified date detailing a fall. The progress note indicated that bed rails were deemed a risk for the resident.

During an observation on a specified date, Inspector #679 observed resident #008 resting in bed with specified bed rails in place.

Inspector #679 reviewed resident #008’s care plan, which indicated an intervention for the use of specified bed rails.

In an interview with RN #122, they indicated that they thought the resident had no bed rails due to a specified safety risk.

Inspector #679 reviewed the home's policy titled “Bed Rail Assessment- Procedure for (B.16.0)” last revised June 11, 2020, which indicated the following resident related risk: Resident climbing over or around the bed rails, in particular residents who have

confusion or responsive behaviours. The policy further indicated that a resident assessment was to be completed by registered staff for all residents when the resident had a significant clinical change.

Inspector #679 reviewed resident #008's paper chart and identified a bed rail assessment dated a specified date, which indicated the use of specified bed rails. The Inspector was unable to identify any further assessments in either the resident's paper or electronic charting.

In an interview with Inspector #679, Manager of Clinical Services #101 indicated that bed rail assessments were completed upon admission, when there was a change in the bed, a change in the resident or if the resident became entrapped. Manager of Clinical Services #101 indicated that the bed rail assessments were completed in the assessment tab. Together, Inspector #679 and Manager of Clinical Services #101 reviewed resident #008's electronic assessments and confirmed no electronic assessment was completed. Manager of Clinical Services #101 indicated that an assessment should have been completed and a request should have been sent to housekeeping to have the specified bed rails removed. [s. 15. (1) (a)]

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 ensuring that residents are assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

Issued on this 10th day of August, 2020

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

Original report signed by the inspector.