Ontario

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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 3, 2013	2013_204133_0023	S-000297-13	Complaint

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

JESSICA LAPENSEE (133)

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): August 20,21,22 - 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Manager for Housekeeping and Laundry Services, Registered and Non Registered Nursing staff, Behavioral Support Staff, Housekeeping Services staff members, the Resident Services Coordinator and the staff member with responsibility for resident accounts.

During the course of the inspection, the inspector(s) reviewed two residents' health care records, reviewed documentation provided by the Administrator and the Director of Care related to complaints, reviewed the home's complaint policy titled "Reporting and Complaints" (#03-27, revised December 4, 2012), reviewed the contents of the 2N care unit "what's happening" binder, observed a resident bedroom on multiple occasions, observed clothing within a resident's closet and dresser drawers to verify the presence of name labels.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 101. Dealing with complaints

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 101 (1) in that the home has failed to deal with a verbal complaint, concerning the operation of the home, as prescribed.

On a day in June 2013, the Ministry of Health and Long-Term Care (MOHLTC) received a complaint that was, in part, related to the conditions in an identified two bed resident bedroom. The complainant alleged that there was a bad smell in the room and the washroom, and this was related to one of the residents who lives in the bedroom (#001), who tended to urinate on the floor. On a day in August 2013, the inspector spoke with the complainant, who indicated that this was an ongoing issue, and that they had made this complaint known to unit staff on many occasions, but did not clarify when and to whom. The complainant stated that no-one at the home was doing anything about their complaint. The complainant is resident #002's Power of Attorney (POA).

During the inspection, the inspector reviewed all of the resident care notes found within resident #002's chart (spanning May - August 2013). On a day in July 2013, there is an entry, made by a Registered Nurse, which indicates that she was called to the identified care unit by the Registered Practical Nurse because resident #002's POA had a complaint. The RN documented that resident #002's POA stated that the resident's washroom is always full of urine and feces. The note goes on to reflect that the resident's POA stated that they "have been to management and the Ministry and they are going to investigate". At this time, the Registered Nurse who made this entry was in receipt of a verbal complaint, related to the conditions of resident #002's bedroom.

During the inspection, August 20th-22nd 2013, it was verified by the inspector that there is a lingering urine odor in the identified bedroom washroom, which is a result of resident #001's tendency to frequently urinate on the bathroom floor. Housekeeping services staff member #S104 indicated to the inspector that this has been a long standing issue. Apart from an enhanced cleaning routine in place for the bedroom during the day shift, the inspector found no other interventions in place to manage this situation.

During the inspection, the inspector was unable to find evidence that the complainant's verbal complaints were handled in accordance with the home's "Reporting and Complaints" policy 03-27 or as prescribed by O. Reg. 79/10, s.101(1).

The complaint process was not initiated, there was no investigation conducted or response provided to the person who made the complaint. [s. 101.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 101 (1) in that the licensee has failed to deal with a verbal complaint, concerning the operation of the home, as prescribed.

On a day in June 25th 2013, the MOHLTC received a complaint that was, in part, related to the condition of an identified two bed resident bedroom at the time that resident #002 was admitted to the room, on a day in May 2013. The complainant alleged that when resident #002 was admitted to the bedroom, the entrance to the room was cluttered with boxes belonging to resident #001. On a day in August 2013, the inspector spoke with the complainant, who indicated that this issue had since been resolved. The complainant explained that they remained frustrated about how long it had taken to resolve the issue, and stated that at the time, staff had not taken their complaints seriously. The complainant indicated that they had made this complaint known to unit staff on many occasions, but did not clarify when and to whom. The complainant is resident #002's Power of Attorney (POA).

On August 20th 2013, during the inspection, the inspector spoke with staff member #S106 and #S107 about resident #001. They indicated that they had past involvement with resident #001, in part, to help the resident manage their belongings. Staff member #S106 explained that resident #001 had an excess of belongings, and that by the time that resident #002 was admitted to the room, on a day in May 2013, the accumulated belongings had been reduced to about ¼ of the original quantity. Staff member #S106 acknowledged that at the time of resident #002's admission to the room, there were boxes of resident #001's belongings lined up against the wall in the entrance to the room.

During the inspection, the inspector reviewed all of the resident care notes found within resident #002's chart (spanning May – August 2013). There are many entries that highlight that the complainant, who is resident #002's POA, was upset that resident #001's excess of belongings were being kept in boxes in the entrance to the room and grew increasingly frustrated about the lack of resolution to the problem. For example, two days after resident #002 was admitted, the 0945 entry reads (in part): "discussed room being over crowded by roommate.....informed i'd see if I could have roommate move boxes @ door today". Later that day, the 1430 entry reflects that

resident #002's POA was in that morning and was upset with the room, and stated that they wanted resident #001's excessive belongings out, and that they would be taking the resident out of the home until the room was cleaned out. Two days later, the 0855-0915 entry details that resident #002's POA had voiced the complaint that the bedroom is full of resident #001's excess belongings. The author of the entry indicates that they advised resident #002's POA that there were staff working on getting the things moved out. Ten days after resident #002 was admitted, the 1730 entry reflects that resident #002's POA was in during the afternoon and had been upset that the boxes of resident #001's excess belongings had not yet been moved out of the room, and had demanded to speak with the Administrator about this. As a result of this demand, the Director of Care (DOC) was apprised of the situation. On that day, the DOC directed staff to move the boxes to a temporary storage area on the unit.

During the inspection, the inspector was unable to find evidence that the complainant's verbal complaints were handled in accordance with the home's "Reporting and Complaints" policy 03-27 or as prescribed by O. Reg. 79/10, s.101(1). The complaint process was not initiated, there was no investigation conducted or response provided to the person who made the complaint. [s. 101.]

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 with the requirement that every written or verbal complaint made to the licensee or to a staff member, concerning the care of a resident or operation of the home is dealt with as prescribed by O. Reg. 79/10, s.101 (1)., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 26. (3)8 in that the licensee has failed to ensure that a resident's plan of care is based on an interdisciplinary assessment of a resident's continence, including bladder and bowel elimination.

On June 25th 2013, the Ministry of Health and Long-Term Care received a complaint that was, in part, related to the conditions in an identified two bed resident bedroom. The complainant alleged that there was a bad smell in the room and the washroom, and this was related to one of the residents (#001) who lives in the bedroom, who tended to urinate on the floor.

During the inspection, on August 20th 2013, at 4:28 pm, the inspector went into the identified resident room and observed a large quantity of urine on the washroom floor and on the floor leading into the washroom . Nursing staff member #S100 explained to the inspector that resident #001 routinely urinates on the washroom floor, and that it is typically a large volume. Later that evening, nursing staff member #S101 explained to the inspector that it is well known that resident #001 urinates on the washroom floor and at times it starts in the area which leads into the washroom.

During the inspection, on August 21st 2013, housekeeping staff member #S102 indicated to the inspector that resident #001 constantly urinates on the bathroom floor. Staff member #S102 told the inspector that the presence of urine on the washroom floor presents a safety risk to the other resident (#002) who resides in the identified bedroom. Later that evening, the inspector spoke with registered staff member #S103, about resident #001 and their tendency to urinate on their washroom floor. Staff member #S103 indicated to the inspector that they did not know this was happening more than occasionally, and agreed that this could present a safety issue, for both resident #001 and #002. The inspector reviewed resident #001's health care record, including the plan of care, and could not find anything related to this behavior. Staff member #S103 acknowledged that there has not been any assessments or interventions related to resident #001's tendency to urinate on the washroom floor. Staff member #S103 implemented an hourly inspection process for the identified bedroom following this conversation.

During the inspection, on August 22nd 2013, the inspector spoke with housekeeping staff member #S104, who explained that it is not unusual for them to clean urine from the washroom floor in the identified bedroom at least 3 times during a shift, and this has been going on for more than a few months. They explained that at times, there is

so much urine that it flows out from the washroom into the entrance of the room. Later that day, at 12:10pm, the inspector noted that unit staff had documented that the washroom floor in the identified bedroom was wet with urine at 8am and at 11:30am. The inspector spoke with registered nursing staff member #S105 who acknowledged that there have not been any assessments or interventions related to resident #001's tendency to urinate on the washroom floor. Staff member #S105 explained that they had not realized that this had been occurring, and that the resident's plan of care would have to be updated accordingly. [s. 26. (3) 8.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 87. (2) d. in that the home has failed to address lingering offensive odors in a resident washroom.

On a day in June 2013, the Ministry of Health and Long-Term Care received a complaint that was, in part, related to the conditions in an identified two bed resident bedroom. The complainant alleged that there was a bad smell in the room and the washroom, and this was related to one of the residents (#001) who lives in the bedroom, who tended to urinate on the floor.

Throughout the inspection, August 20th-22nd 2013, the inspector noted a lingering urine odor in the identified bedroom washroom. The odor was noted despite an enhanced cleaning routine in place, during the day shift, for the bedroom washroom.

Upon arrival to the home on August 20th 2013, the inspector proceeded to the identified bedroom and observed a large amount of urine on the bathroom floor and also in the area leading into the bathroom. Throughout the inspection, the inspector spoke with staff (#S100, #S101, #S102, #S103, #S104) about this. In summary, it was explained to the inspector that one of the residents who resides in the identified bedroom, resident #001, tends to urinate, frequently, on the washroom floor and it is not unusual that the urine is found within the entrance area of the bedroom, leading into the washroom. As well, it is not unusual that there is a very large quantity of urine on the floor. Staff member #S102 accompanied the inspector into the washroom, on August 21st 2013, at 9:10 am, after the washroom had been cleaned, and agreed there was a lingering urine odor. Staff member #S103 accompanied the inspector into the washroom, on August 21st at 5:45pm, and agreed there was a lingering urine odor despite the washroom appearing to be clean. During the inspection, on August 22nd 2013, staff member #S104 acknowledged that routine cleaning of the washroom does not eliminate the lingering urine odor. [s. 87. (2) (d)]

Issued on this 3rd day of September, 2013

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

Jessica Lapensée