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
Feb 26, 2014	2014_282543_0006	S-000276-13	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

TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 18th-21st, 2014

Enter any additional information..the following logs were reviewed as part of this inspection: S-000276-13, S-000383-13, S-000442-13, S-000457-13, S-000035-14, S-000043-14.

During the course of the inspection, the inspector(s) spoke with the Manager of Clinical Standards, Clinical Services Administrative Assistant, Registered Nurse (s), Registered Practical Nurse(s), Personal Support Worker(s), Behavioural Support Staff and Resident(s)

During the course of the inspection, the inspector(s)
-Directly observed the delivery of care and services to residents
-Conducted daily tours of all resident home areas
-Reviewed staff education events
-Reviewed resident health care records
-Reviewed various home policies and procedures

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. Inspector #543 reviewed resident #005's progress notes; it was documented that resident #005 exhibited wandering behaviours. In September, 2013 at 1000hrs, a PSW on the resident's unit had to redirect resident #005 from attempting to enter elevator, back to common sitting area on the unit. On the same day at 1040hrs, it was documented that the physician saw the resident sitting in the foyer of the Home. On that same day, at 1130hrs, the Home was notified that resident #005 was located near a store on Cassells St., by a bystander, who called ambulance to have resident assessed at the hospital, due to resident's complaints of pain. Inspector #543 received documentation from the Home stating, that a staff member wrote in a letter to Management that she witnessed resident #005 exiting the building accompanied by visitors. The staff member identified in the letter, that she was under the impression that resident #005 was leaving for an outing with family members. Inspector #543 reviewed Home's policy- Watchmate System-Procedure for Use of (W2.0) which states; the system was implemented for residents at high risk of elopement. The system consists of a bracelet placed on the wrist or ankle of a resident that will alarm when a resident is nearing an exit in the building. When the alarm sounds staff members must identify the ID number and locate the resident with same ID number. The alarm cannot be turned off until the resident is located and safe in the Home. The staff member admitted to not adhering to the Home's Policy relating to the Watchmate Bracelet System. Thus, the licensee did not ensure that the home was a safe and secure environment for resident #005. [s. 5.]

WN #2: 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. A staff member within the Home witnessed another staff member physically abuse resident #003. Incident occurred on October 29th, 2013 but was not reported to registered staff or management until November 4th, 2013. The Home's policy- Resident Rights: Prevention of Abuse and Neglect states that any person reporting an alleged, suspicious or witnessed incident of abuse or neglect will immediately report the incident to the RN supervisor and document a brief factual note in the resident nursing notes. Thus, the licensee did not ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

Issued on this 28th day of February, 2014

[redacted]

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

Tiffany Bucalo (#543)