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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 8, 2015	2015_395613_0006 (AI)	S-000444-14, S-000495-14, S-000575-14, S-000508-14	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

LISA MOORE (613)

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): May 4, 5, 6, 7 and 8, 2015

related to Ministry of Health and Long Term Care logs S-000444-14, S-000495-14, S-000575-14, S-000508-14

During the course of the inspection, the inspector(s) spoke with Manager of Clinical Standards, Manager of Activities, RAI Coordinator, Registered Staff (RN/RPNs), Personal Support Workers and Housekeeper.

The inspector observed the provision of care and services to the residents, observed staff to residents interactions, conducted a walk through of the home daily, completed health care record reviews, reviewed applicable home policies, procedures, resident plans of care and complaint logs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities

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	Legendé 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan 2007, c. 8, s. 6 (7).

According to information received by the Ministry of Health and Long - Term Care on September 11, 2014 resident #001 sustained an unwitnessed fall resulting in a fracture. On September 12, 2014, family arrived in the evening to the resident's room to find resident #001 sitting in their wheelchair in the dark with no shoes on and the seat belt unbuckled. When family approached S#115 about the occurrence, S#115 stated they were unaware how to undress resident due to their injury and left the resident alone in the room while they went to ask their partner (another PSW) how to perform the care.

Inspector #613 reviewed documentation in the home's complaint file. This file included a Complaint Documentation Form, response letter from the home to the complainant, documentation from staff working, the home's investigation notes and an employee counselling record.

A review of the home's investigation identified that S#115 did not receive the verbal shift report or review "The What's Happening Binder", unit report prior to commencing the scheduled shift. S#115 admitted they did not know where the unit report was kept and did not know how to check the Point of Care (POC) computer documentation to review resident's kardex in order to know how to meet resident's care needs. S#115 admitted that they did not know resident had a fracture until later in the evening when they brought resident to their room to begin bed time care. S#115 did not know how to provide care due to the resident's injury, therefore, according to the home's investigation; S#115 did not provide care to the resident as specified in the care plan.

In the home's investigation notes, in an email dated September 12, 2014, regarding resident #001 it was noted by S#116 that resident #001's care plan was updated and notes regarding resident #001's current care needs were highlighted in, "The What's Happening Binder" (unit report) to notify all staff. Inspector noted in the progress notes on September 11, 2015, post resident #001's return from hospital that care plan had been updated post fall to include, resident #001 to wear a medical device day and night until follow up appointment in orthopedic clinic the following week, all ADL's extensive assistance for care with two person transfers and use 15lb seat belt at all times until cast applied. The home's investigation notes also included that S#115 admitted to S#116 that they did not turn lights on when they left the room. In the documentation six (6) days later during investigation with Director of Care dated September 18, 2014, S#115 stated the main ceiling light was on but the bedside light was not on, referring that resident room was not dark. The complainant had been upset to find resident #001's room dark and sitting in their wheelchair with no shoes or seat belt applied upon their arrival the evening of September 12, 2014, due to safety concerns and resident #001's fall one day prior.

Inspector reviewed resident #001's care plan for the time period post fall and post family voicing their concern. It was noted that the care plan had been updated and identified that resident had a fracture with use of a medical device; requiring total assistance with care and ceiling lift to be used with two (2) staff for all transfers. On September 12, 2014 and post fall, the care plan identified resident #001 was to wear proper and non slip footwear. In the home's investigation notes, S#115 stated resident was wearing leather slip on shoes. Care plan identified resident was to use a 15lb seat buckle when in wheelchair. S#115 stated resident undid seat buckle per self. Inspector reviewed progress notes from September 12, 2014 back to March 1, 2014 and was unable to locate documentation to confirm resident was capable of removing 15lb seat buckle. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #006.

Inspector #542 reviewed the most recent care plan for resident #006 and noted that under the "focus" statement for PASD it indicated that a specific device is to be placed on right side between mattress and bed rail. On May 8th, 2015, Inspector observed resident #006 had 2 full bed rails raised while in bed with no device as indicated in resident's care plan. Inspector then reviewed the "Bed Rails Risk Assessment" completed on March 23, 2015 and noted that this document also indicated that a device was to be placed in the same location as the resident was at risk of becoming lodged. S#105, S#117 and S#118 were unable to locate the device in the resident's bed or room. S#118 stated that they have never seen the device in this resident's bed or room. Registered staff proceeded to obtain the device to place on the bed as indicated in the plan of care for resident #006. [s. 6. (7)]

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 the care set out in the plan of care for residents #001 and #006 is provided to the residents as specified in the plan of care., to be implemented voluntarily.

Issued on this 8th day of July, 2015

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

Lisa Moore

Original report signed by the inspector.