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
Nov 30, 2015	2015_283544_0028	011321-15	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

FRANCA MCMILLAN (544)

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): November 9, 10, 11, 2015.:

Enter any additional information.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Staff, Personal Support Workers (PSWs), Dietary Staff, Behavioural Support Ontario Staff (BSO), Resident and Families.

Inspector also toured the home daily, observed staff to resident interaction, staff providing care and services to residents, residents who exhibited responsive behaviours and staff interventions, beverage and snack passes and residents receiving physiotherapy services.
Inspector reviewed residents' health care records, progress notes, care plans, Responsive Behaviours Program and other documentation related to responsive behaviours, Restorative Care Program and other documentation relevant to this inspection.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Dignity, Choice and Privacy
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours included: assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

Inspector # 544 reviewed information related to a resident who exhibited responsive behaviours.

A Critical Incident was inspected during this complaint inspection since it was in relation to the same resident issues.

The complainant alleged that resident # 002 assaulted staff and tried to run over staff and other residents with their wheelchair. Due to resident # 002's responsive behaviours, staff and other residents were afraid. The complainant alleged that management was not taking this seriously.

On reviewing resident 002's nursing progress notes, the inspector noted that the aggressive verbal and physical responsive behaviours had occurred. The staff attempted to remove resident # 002 from the area but most times were unsuccessful. This was confirmed by S # 112 who reviewed resident # 002's health care records with the inspector.

Inspector reviewed the BSO progress notes and identified multiple episodes whereby, resident # 002 exhibited aggressive physical and verbal responsive behaviours. The BSO progress notes also identified resident # 002's aggressive physical and verbal

threats and that responsive behaviours had increased in intensity and frequency. According to the BSO progress notes, resident # 002 frightened the staff and other residents to a high degree.

Inspector reviewed resident # 002's care plan and noted that behavioural triggers and strategies to manage resident # 002's responsive behaviours were not identified. Staff attempted to deal with these responsive behaviours, as they occurred, without clear strategies. The resident's responses to these strategies were not documented.

There were two "Resident Situational Case Conferences" held with multiple staff members in attendance. There were no further conferences held as confirmed by S # 100 and S # 112. There was no documentation of these conferences to support that the "Resident Situational Conferences" provided strategies to assist the staff.

Inspector interviewed S # 100 who told the inspector that the Community Mental Health Services had withdrawn their services from the home and were no longer providing support or accepting resident referrals. Therefore, no further assessments or re-assessments were conducted with resident # 002. S # 100 was attempting to reconnect with the Community Mental Health Services to assist the home with strategies and recommendations in caring for residents exhibiting responsive behaviours. Inspector interviewed S # 107, S # 108, S # 109 and S # 110. They told the inspector that resident # 002 threatened them and other staff and residents on a daily basis. The BSO staff stated that they are not successful in managing resident # 002's responsive behaviours and resident # 002 becomes more aggressive verbally and agitated when they attempt to intervene.

Inspector interviewed S # 113 who had conducted counseling sessions with resident # 002. There was no documentation to support the content or outcomes of these counseling sessions as confirmed by S # 113. S # 113 confirmed that there should have been more counseling sessions planned and strategies developed and implemented to assist staff in caring for resident # 002's responsive behaviours. S # 113 stated that an evaluation of the strategies should also have been completed.

Inspector interviewed S # 103, # 104 and S # 110, S # 112 and S # 113 who told the inspector that resident # 002's aggressive physical and verbal responsive behaviours were difficult to manage and had increased in frequency and intensity.
They told the inspector and confirmed that another assessment or reassessment should have been conducted by a specialist or follow-up on the recommendations by the

previous specialist. They also agreed that another "PIECES of MY Personhood" should have been conducted. They felt more frequent "Resident Situational Case Conferences" should have been planned, conducted, the outcomes documented and any recommendations acted upon.

Inspector observed resident # 002, over the course of three days, and identified that resident # 002 continued to intimidate and verbally threaten staff and other residents in the home. Inspector observed resident # 002 was aggressive in their tone of voice, used profane language and moved about quickly bumping into residents, staff, visitors, linen carts and other equipment in the hallway.. Staff responded to these episodes and offered support and tried to re-direct resident # 002 and calm them, however, the responsive behaviours continued. Inspector observed that BSO were called to assist with these episodes but this only angered resident # 002 further.

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 actions taken to meet the needs of the resident with responsive behaviours include: assessment, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 57. Integrating restorative care into programs
Every licensee of a long-term care home shall ensure that,
(a) restorative care approaches are integrated into the care that is provided to all residents; and
(b) the restorative care approaches are co-ordinated to ensure that each resident is able to maintain or improve his or her functional and cognitive capacities in all aspects of daily living, to the extent of his or her abilities. O. Reg. 79/10, s. 57.

Findings/Faits saillants :

1. The licensee has failed to ensure that restorative care approaches were coordinated so that the resident is able to maintain or improve their functional and cognitive capacities in all aspects of daily living, to the extent of their abilities.

Inspector reviewed a complaint, received by the Director, related to care of a resident.

According to the complainant, therapy services were no longer being offered to resident # 001.

Inspector reviewed resident # 001's health care record and identified a progress note that confirmed that therapy services had been withdrawn. There was no further assessment or re-assessment completed in regards to therapy or restorative care.

Inspector reviewed resident # 001's care plan and identified that there was no focus, goals or interventions regarding a restorative care program for resident # 001. Restorative care approaches were not developed, coordinated or implemented.

In an interview with outside staff and the family, they told the inspector that a restorative care program would benefit resident # 001 and questioned why it was not being continued. The family told the inspector that there was no discussion with them. A re-assessment was not conducted to re-initiate this restorative care service.

Inspector interviewed S # 100 who told the inspector that the expectation is, even though residents may have outside staff, the home's staff are to ensure that resident # 001's care needs are met. This included a restorative program for resident # 001. This was confirmed by S # 102 and S # 103. S # 100 S # 102 and S # 103 also confirmed that a new therapy referral should have been sent and resident # 001 should have been re-assessed.
The above staff members told the inspector that therapy and/or restorative care should be in the care plan.

Over the course of two (2) days of the inspection, inspector observed documentation which contained range of motion exercises and strengthening exercises. The restorative care, specifically the range of motion and the strengthening exercises, were not provided to resident # 001.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident # 001 was offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

The family alleged that resident # 001 was not receiving or being offered an in between meal beverage in the morning, afternoon and evening.

The family and outside staff felt that the home's staff should have provided this service. The home's staff assumed that the private care staff would look after this need.

Inspector interviewed the outside staff and family who told the inspector that the home's staff was not providing a beverage to resident # 001 mid morning, afternoon and evening since the hiring of the private duty staff.

Inspector interviewed S # 100 who told the inspector that the expectation is, even though residents may have outside staff, the home's staff are to ensure that resident# 001's care needs are met. Upon questioning the home's staff, S # 100 confirmed that resident # 001 was not being offered an in between meal beverage in the morning, afternoon and evening. Staff thought that the private duty care aide provided this service to resident # 001. This was also confirmed by S # 103.

Inspector reviewed resident # 001's health care record and identified that there was no documentation to support that resident # 001 was offered a beverage, had received a beverage or refused a beverage for the mid morning, afternoon and evening beverage pass by the staff until recently.

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Issued on this 30th day of November, 2015

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

Original report signed by the inspector.