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
Direction de l'amélioration de la performance et de la conformité

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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
Jan 13, 2016	2015_336620_0009	032277-15	Resident Quality Inspection

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

ALAIN PLANTE (620), CHAD CAMPS (609), FRANCA MCMILLAN (544)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 07-15, 2015

During the course of this RQI Critical incidents (CI) were also inspected. The CIs included:
four incidents of alleged staff to resident verbal abuse;
an incident involving a fall that resulted in a fracture;
an incident of alleged incompetent treatment of a resident;
an incident of alleged incompetent treatment of a resident that resulted in injury.

During the course of the inspection, the inspector(s) spoke with Residents, Substitute Decision Makers (SDM), residents' family members, the Administrator, the Vice President of Clinical Services (VPCS), the Manager of Clinical Services (MCS), the Medical Director (MD), Registered Nurses (RN), the Registered Dietitian (RD), Registered Practical Nurses (RPN), Food Services Supervisors (FSS), the Manager of Laundry Services, Personal Support Workers (PSW), a Food Service Worker, and a Dietary Aid.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

8 WN(s)
5 VPC(s)
2 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-resident areas were equipped with locks to restrict unsupervised access to those areas by residents and that the doors were locked when they were not being supervised by staff.

During the initial tour of the home, Inspector #609 observed that the tub room doors on the Maple Street, Apple Street, and Cherry Lane units were unlocked and unattended. All three tub rooms had cleaning chemicals readily visible and accessible. On December 8, 2015 the inspector observed the Maple Street Tub Room and the second floor Utility Room unlocked and unattended.

An interview with staff member #103 revealed that the tub and utility room doors in the home have locks that required staff to turn the handle counter clockwise in order to activate. They stated that staff were not aware that the handle needed to be turned counter clockwise in order to activate the locks.

An interview with a staff member confirmed that it was the expectation of the home that all doors leading to non-residential areas were to be locked when not being supervised by staff, that in the case of the tub and utility room locks not being correctly engaged by staff this did not occur and should have. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

A Critical Incident Report (CI) was submitted to the Ministry which indicated resident #029 was served food during a meal service that resulted in injury to the resident.

A review of the home's policy titled "Hot Holding" last revised December 2015, revealed that all foods were to have temperatures checked and recorded before serving and that the temperature of the foods were not to be served if outside of 140-165 degrees Fahrenheit.

A review of the home's internal investigation revealed the last temperature taken of the food served to resident #029 was 180 degrees Fahrenheit.

On December 14, 2015, an audit of the daily food temperature logs was conducted on two units in the home. The audit revealed that 66 per cent of the time, hot cereal temperatures were not recorded.

An interview with staff member #120 confirmed that it was the expectation of the home that all food temperatures were to be checked and recorded to ensure the food was served to residents at a safe temperature. They confirmed that this did not happen for resident #029 which resulted in injury to the resident and that this injury should not have occurred.

An interview with staff member #120 further confirmed that there was no way to ensure that foods were served at a safe temperature if the temperatures were not checked and recorded before serving as the audit by Inspector #609 revealed and that staff required retraining to ensure the policy was complied with. [s. 73. (1) 6.]

2. The licensee has failed to ensure that the meals were served course by course.

Inspector #544 observed a lunch dining service and identified that in two resident dining areas staff were serving the dessert course before the residents had finished their main course.

Inspector #544 interviewed the staff member #106 who told the inspector that the expectation was that each meal course was to be served course by course. This was also confirmed by staff member #108.

Inspector #544 interviewed staff member #107, and #105 who told the inspector that they were aware that each meal course was to be served course by course. Both staff members confirmed that they had served the dessert course before residents had finished their main course. [s. 73. (1) 8.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the home is equipped with a staff-resident communication system that can be easily seen, accessed and used by residents, staff, and visitors at all times.

Inspector #620 observed that in a certain room there was no call bell attached to the panel by the bed and there was no way to activate the call system; furthermore, the call bell panel was not accessible because access was blocked by furniture and other items. Likewise, there was no bedside call bell in place for three other rooms within the home.

Inspector #620 reviewed the home's policy #O8.0 titled, "Monitoring Physically/Cognitively impaired Residents; Call Bell System-Resident 24 Hour." The policy revealed that when residents were unable to use a call bell or when the call bell posed a threat to the residents' safety, the call bell was to be bundled and secured with a twist tie at the wall outlet.

Inspector #620 interviewed staff member #113. They stated that the call bell had been "plugged" for the resident's safety and inability to use the call bell. Staff member #113 confirmed that staff were expected to pull the plugged jack from the wall in order to activate the call bell. They stated that family were expected to leave the bedside to get a staff member if assistance was required.

Inspector #602 interviewed staff member #102 who stated that family or staff could use the bathroom call bell to get assistance if necessary. The staff member was unaware of the requirement to have a visible, accessible call bell at the bedside if the resident was unable to use the call system due to cognitive impairment.

Inspector #620 interviewed the home's Administrator on December 10, 2015. The Administrator confirmed that it was the home's expectation that the LTCHA be complied with. They confirmed that in the case of the call system in four of the home's rooms the call system was not visible and accessible to staff, and visitors at the bedside, and should have been. [s. 17. (1)]

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 the home is equipped with a staff-resident communication system that can be easily seen, accessed and used by residents, staff, and visitors at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that the abuse of resident #010 and 011 by staff member #114 that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #620 conducted an inspection related to a critical incident which described staff to resident verbal abuse.

Inspector #620 reviewed the home's CI reports. The description of the incident revealed that staff member #114 chastised resident #010. Staff member #115 who witnessed the incident reported that staff member #114 was rude and sarcastic with resident #010. Staff member #114 was also involved in a second incident on the same day. The CI report noted that resident #011 was spoken to rudely by staff member #114. The incident was witnessed by staff member #116 and 117 and reported to staff member #104 on November 14, 2014.

A review of the home's investigation documents revealed that staff in the home were aware of the incident of verbal abuse; however, a report was not made to the Director until four days had passed. The documents also revealed that staff member #114 received disciplinary action as a result of the home's investigation.

The home's Abuse, Neglect and Retaliation Prevention Policy (A4.0) stated that incidents of abuse were expected to be submitted immediately to the MOHLTC.

Inspector #620 interviewed the staff member #103. They confirmed that both resident #010 and 011 were verbally abused by staff member #114. They also confirmed that it is the home's expectation that incidents of abuse were to be reported to the Director immediately. Staff member #103 stated that in the case of verbal abuse involving resident #010 and 011 by staff member #114 the home did not immediately report the incident to the Director, and should have. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated when a change of 7.5 per cent of body weight, or more, over three months had occurred.

A review of resident #002's clinical record by inspector #620 revealed a loss 7.7 per cent weight loss over three months. A review of the resident's plan of care revealed that no interdisciplinary assessment or documented intervention occurred following the weight loss.

Inspector #620 reviewed the home's policy (W3.0) titled, "Weighing Residents – Procedure for Documenting in POC." The purpose of the policy was to ensure routine

monitoring of weights monthly, and to identify weight loss or gain and ensure corrective measures were taken when appropriate. The policy's procedure called for a staff member to generate a monthly report for review by another staff member. A staff member was also expected to generate a weight report to determine the per cent of unplanned weight loss. The policy stated that if a resident had a weight loss, a staff member was expected to initiate a high nutritional risk screening immediately. The policy further noted that the care plan was to be updated by a staff member; furthermore, the RD was to assess and complete the nutritional care plan in collaboration with registered staff.

Inspector #620 interviewed staff member #121. They confirmed that resident #002 had a weight loss of greater than 7.5 per cent. They also stated that they were unaware of the weight change and should have been made aware. They stated that the expectation was that RNs would notify the RD of any significant weight changes. Staff member #121 confirmed that with respect to resident #002 no assessment or intervention occurred as a result of the weight loss, and should have.

Inspector #620 interviewed staff member #103. They confirmed that resident #002 had a weight loss of 7.5 per cent. The staff member noted that the weight loss should have been reported. They stated that a staff member should have then completed a requisition to the RD for further assessment. They confirmed that in the case of resident #002 the RD had not been notified of the weight loss as was required by the home's policy, and should have been. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. The licensee has failed to ensure that resident #005 was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated when a change of 10 per cent of body weight, or more, over six months had occurred.

A review of the home's clinical record by inspector #620 revealed that resident #005 had a documented weight loss of 10.7 per cent body weight over six months. A review of the resident's plan of care revealed that no interdisciplinary assessment or documented intervention occurred following the weight loss.

Inspector #620 reviewed of the home's policy titled, "Weighing Residents – Procedure for Documenting in POC." The purpose of the policy was to ensure routine monitoring of weights monthly, and to identify weight loss or gain and ensure corrective measures were taken when appropriate. The policy's procedure called for a staff member to generate a monthly report for review by the RN. The RN was also expected to generate a weight report to determine the per cent of unplanned weight loss. The policy stated that

if a resident had a weight loss, the RN was expected to initiate a high nutritional risk screening immediately. The policy further noted that the care plan was to be updated by the RN and/or the RD; furthermore, the RD was to assess and complete the nutritional care plan in collaboration with registered staff.

Inspector #620 interviewed the RD. They confirmed that resident #005 had a weight loss of greater than 10 per cent. They also stated that they were unaware of the weight change and should have been made aware. They stated that the expectation was that RNs would notify the RD of any significant weight changes. The RD confirmed that with respect to resident #005 no assessment or intervention occurred as a result of the weight loss, and should have.

Inspector #620 interviewed staff member #103. They confirmed that resident #005 had a weight loss of 10 per cent, over six months. They noted that the weight loss should have been reported. They stated that they should have then completed a requisition to the RD for further assessment. They confirmed that in the case of resident #005 the RD had not been notified of the weight loss as was required by the home's policy (W3.0), and should have been. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 using an interdisciplinary approach, and that actions are taken and outcomes are evaluated when a change of 7.5 per cent of body weight, or more, over three months and a change of 10 per cent of body weight, or more, over six months has occurred, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

Observations during the initial tour of the home revealed:

a) An unlocked and unattended kitchenette in the home's Chapel with corrosive cleansers visible and accessible;
b) The tub rooms on Maple and Apple Street as well as Cherry Lane were observed unlocked and unattended with cleaning chemicals visible and readily accessible;
c) Observations of the unattended housekeeping cart on Willow Street revealed corrosive cleaning chemicals visible and readily accessible.

An interview with the staff member #103 confirmed that it was the expectation of the home that all hazardous substances at the home were to be kept inaccessible to residents at all times, that in the case of the cited accessible hazardous chemicals this did not occur and should have. [s. 91.]

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 all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations.

A review of the home’s policy titled “Abuse, Neglect and Retaliation Prevention” last revised May 7, 2015, revealed that there was no mention of the relationship between power imbalances between staff and residents or how to avoid such situations that may lead to abuse and neglect.

A review of the home’s 2015 Abuse and Neglect training module revealed no mention of the relationship between power imbalances between staff and residents or how to avoid such situations that may lead to abuse and neglect.

An interview with staff member #103 confirmed that it was the expectation of the home that the relationship between power imbalances between staff and residents and how to avoid such situations that may lead to abuse and neglect should have been identified in the abuse policy and the 2015 abuse training module and that this did not occur, and should have. [s. 96. (e)]

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 the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including:

i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

ii. situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

A review of the home's policy titled "Abuse, Neglect and Retaliation Prevention" last revised May 2015 indicated that the home's management was to annually evaluate the effectiveness of the home's policy for prevention of abuse and neglect to identify what changes and improvements were required to prevent further occurrences.

An interview with staff member #103 revealed the home did not have an annual evaluation of the home's policy on zero tolerance of abuse and neglect of residents. They confirmed that it was the expectation of the home that an annual evaluation of the effectiveness of the home's policy on zero tolerance of abuse and neglect of residents was to be completed, and that in the case of the 2014 year this did not occur and should have. [s. 99. (b)]

Issued on this 13th day of January, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALAIN PLANTE (620), CHAD CAMPS (609), FRANCA MCMILLAN (544)
Inspection No. / No de l'inspection :	2015_336620_0009
Log No. / Registre no:	032277-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 13, 2016
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST 400 Olive St., NORTH BAY, ON, P1B-6J4
LTC Home / Foyer de SLD :	CASSELLHOLME 400 OLIVE STREET, NORTH BAY, ON, P1B-6J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jamie Lowery

To BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall:

a. audit all doors leading to non-resident areas including tub rooms, utility rooms, stairways, and the outside of the home to ensure that the locking devices function;

b. act on the results of this audit to ensure that all improperly functioning door locks are repaired;

c. ensure that doors awaiting repair are secured in such a way that residents are unable to gain access to non-resident areas until repairs have been completed;

d. ensure that a record is maintained of the audit results and all subsequent repairs;

e. ensure that all staff are trained related to which doors of the home are to be kept locked, how locking devices are to be activated, and that a record of this training is maintained.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that all doors leading to non-resident areas were equipped with locks to restrict unsupervised access to those areas by residents and that the doors were locked when they were not being supervised by staff.

During the initial tour of the home, Inspector #609 observed that the tub room doors on the Maple Street, Apple Street, and Cherry Lane units were unlocked and unattended. All three tub rooms had cleaning chemicals readily visible and accessible. On December 8, 2015 the inspector observed the Maple Street Tub Room and the second floor Utility Room unlocked and unattended.

An interview with staff member #103 revealed that the tub and utility room doors in the home have locks that required staff to turn the handle counter clockwise in order to activate. They stated that staff were not aware that the handle needed to be turned counter clockwise in order to activate the locks.

An interview with the a staff member confirmed that it was the expectation of the home that all doors leading to non-residential areas were to be locked when not being supervised by staff, that in the case of the tub and utility room locks not being correctly engaged by staff this did not occur and should have. [s. 9. (1) 2.] (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall:

a. complete an audit of the home's monitoring of food temperatures which has occurred for all meal services within the last four months, maintain a record of this audit, and act on the results;

b. revise the home's policy for monitoring of food temperatures ensuring that it includes a process to eliminate the potential for residents to be served food at unsafe temperatures;

d. ensure that training on the revised policy is provided for staff who are required to monitor food temperatures, and that a record of the training is maintained.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

A Critical Incident Report (CI) was submitted to the Ministry which indicated resident #029 was served food during a meal service that resulted in injury to the resident.

A review of the home's policy titled "Hot Holding" last revised December 2015, revealed that all foods were to have temperatures checked and recorded before serving and that the temperature of the foods were not to be served if outside of 140-165 degrees Fahrenheit.

A review of the home's internal investigation revealed the last temperature taken of the food served to resident #029 was 180 degrees Fahrenheit.

On December 14, 2015, an audit of the daily food temperature logs was conducted on two units in the home. The audit revealed that 66 per cent of the time, hot cereal temperatures were not recorded.

An interview with staff member #120 confirmed that it was the expectation of the home that all food temperatures were to be checked and recorded to ensure the food was served to residents at a safe temperature. They confirmed that this did not happen for resident #029 which resulted in injury to the resident and that this injury should not have occurred.

An interview with staff member #120 further confirmed that there was no way to ensure that foods were served at a safe temperature if the temperatures were not checked and recorded before serving as the audit by Inspector #609 revealed and that staff required retraining to ensure the policy was complied with. [s. 73. (1) 6.] (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alain Plante

Service Area Office /
Bureau régional de services : Sudbury Service Area Office