Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 1, 2019	2019_565647_0019	009001-19, 009292-19, 009801-19, 013551-19	Critical Incident System

Licensee/Titulaire de permis

The Board of Management for the District of Nipissing East
400 Olive Street 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

JENNIFER BROWN (647), CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 23 - 26, 2019.

The following intakes were completed during the course of this Critical Incident System (CIS) inspection:
-Two intakes related to neglect of a resident, and
-Two intakes related to resident to resident abuse.

Complaint inspection #2019_565647_0017 and Follow Up inspection #2019_565647_0018 were conducted concurrently with this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Acting Director of Clinical Services (DOC), Manager of Clinical Services, Unit Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Substitute Decision Makers (SDMs), and residents.

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed staff to resident interactions and the provisions of care, reviewed training documents, and policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
2 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	Légende 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. 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. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The Long-Term Care Homes Act (LTCHA),2007 defines neglect, as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident (CI) report was submitted by the home to the Director on an identified date, which outlined how resident #009, was found, with an injury.

Inspector #609 reviewed the home's internal investigation of the incident, which identified that resident #009 had fallen. The resident indicated that no one had checked on them until the next morning when their injury was identified and treated.

A review of the home's policy titled "Abuse, Neglect and Retaliation Prevention" last revised July 5, 2018, indicated that all residents had the right to live in a home environment that treated them with dignity, respect and was free from any form of abuse or neglect at all times and in all circumstances.

a) During an interview with the Manager of Clinical Services, a review of the home's internal investigation of the incident was conducted with Inspector #609. The Manager of Clinical Services outlined how Personal Support Worker (PSW) #106 was working and assigned to resident #009, however, they did not perform a proper check of the resident.

PSW #106 was unavailable for an interview during the course of the inspection.

During an interview with resident #009, they outlined how they had fallen and had no recollection of any staff checking on them after the fall.

A review of the home's policy titled "Nursing Rounds & Hourly Resident Checks" last revised July 13, 2017, required PSWs to visually identify that the resident was present and did not have any health concerns that needed immediate attention. If it was dark while performing the check, a flashlight must be used in the resident's room. Any concerns identified during rounds must be reported immediately to the registered staff

charge nurse for assessment.

During interviews with PSW #110 and #111, both outlined that to perform a proper hourly check of a resident, they would need to enter the room and verify that the resident was breathing and if it was dark, then they were required to use a flashlight to visualize the resident.

A review of the PSW’s letter of discipline, indicated that the PSW’s "failure to complete proper checks resulted in neglect of the resident and a delay in their medical treatment".

b) During an interview with PSW #107, they verified that they were working on the identified date, and resident #009 was assigned to them. They described that when they checked the resident, the resident's back was turned towards them. The PSW further described that it was dark, they did not see any injury to the resident, and denied using a flashlight to visualize the resident.

A review of PSW #107’s letter of discipline, indicated that they "failed to carry out a proper check on the resident which compromised the resident’s safety, comfort, delayed a timely medical intervention and amounted to neglect of duty".

c) A review of the home’s internal investigation of the incident was conducted with the Manager of Clinical Services. They verified that Registered Practical Nurse (RPN) #105 was notified by PSW #106 that there could potentially be a concern with resident #009.

RPN #105 was unavailable for an interview during the course of the inspection.

A review of RPN #105’s letter of discipline, outlined how they "did not take the time to assess resident #009 and as a result, delayed medical intervention of the resident’s injury". The letter further outlined that it was the "expectation of the home that the RPN was to investigate any situation that was reported to them that could point to a possible resident injury".

During an interview with the Manager of Clinical Services, they indicated that the lack of proper hourly checks by PSW #106 and #107 and the lack of assessment by RPN #105 constituted neglect of resident #009. [s. 20. (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 to ensure that the home’s written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (6) Every licensee of a long-term care home shall ensure that the following are done:
1. The further training needed by the persons mentioned in subsection (1) is assessed regularly in accordance with the requirements provided for in the regulations. 2007, c. 8, s. 76. (6).
2. The further training needs identified by the assessments are addressed in accordance with the requirements provided for in the regulations. 2007, c. 8, s. 76. (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the further training needs identified by the assessments were addressed in accordance with the requirements provided for in the regulations.

In accordance with O. Reg. 79/10, s. 219 (3)(b), for the purposes of subsection 76 (6) of the Act, the further training needs identified by the assessments shall be addressed in the manner the licensee considers appropriate.

A Critical Incident (CI) report was submitted by the home, which outlined how resident #009 was found, with an injury, but was not found until the morning.

During an interview with the Manager of Clinical Services, they outlined to Inspector #609 , that an incident occurred whereby, resident #009 fell, and sustained an injury. The home’s investigation found that staff had not performed hourly rounds. The home then implemented hourly rounds retraining of all full and part time PSWs to be completed in two week.

A review of the home’s internal investigation of the incident found that the PSW #106 and #107 had not completed proper hourly rounds of resident #009.

During an interview with PSW #107, they stated that they did not complete the hourly rounds retraining.

A review of the “Policy Sign Off Sheet” for hourly rounds retraining, found that PSW #107 did not complete the retraining.

During the same interview with the Manager of Clinical Services, they verified that PSW #107 should have received the hourly rounds retraining but had been missed. [s. 76. (6) 2.]

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 further training needs identified by the assessments are addressed in accordance with the requirements provided for in the regulations, to be implemented voluntarily.

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, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of, (c) a snack in the afternoon and evening.

A Critical Incident (CI) report was submitted by the home, which outlined complaints from resident #010, that they did not receive any nourishment from the cart during the evening on an identified date.

During an interview with resident #010, a review of the CI report allegations was conducted by Inspector #609. They told Inspector #609 that they could not remember the specific dates but could recall that up to three times that week, snacks were not offered to them when the cart passed by in the evening.

A review of resident #010's Point of Care documentation found that the resident was recorded as "resident refused" for the identified date, during the evening nourishment pass.

A review of the home's internal investigation, showed camera footage that PSW #123 did not go into three residents' rooms (which included resident #010) to offer nourishment but documented that the residents refused or were unavailable during the specified shift.

PSW #123 was unavailable for an interview during the course of the inspection.

During an interview with the Manager of Clinical Services, they indicated that a review of the camera footage showed that PSW #123 performed the evening nourishment pass "fast" on the identified date, and could not have provided the snacks to the residents in that short a time frame. They also verified that the PSW did not go into some of the residents' rooms.

A review of a discipline letter to PSW #123, outlined how, during the identified nourishment pass, they documented that 66 per cent of residents on the unit refused nourishment yet did not go into some of the residents' rooms to provide nourishment. [s. 71. (3) (c)]

Issued on this 1st day of August, 2019

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

Original report signed by the inspector.