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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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_0017	012240-19	Complaint

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 Complaint inspection.

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

The following intake was inspected during the course of this Complaint Inspection:
-one intake was related to complaints of improper care to a resident.

Follow Up inspection #2019_565647_0018 and Critical Incident inspection #2019_565647_0019 were conducted concurrently with this Complaint 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 this 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:
Personal Support Services

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	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. 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 for resident #008, #016, and #017, were provided to the residents as specified in the plans.

A complaint was submitted to the Director, which outlined concerns related to the improper care of resident #008.

a) Inspector #609 reviewed resident #008's plan of care, which indicated, an identified focus with a specified intervention.

On an identified date and time, resident #008 was observed without the specified intervention.

During an interview with Personal Support Worker (PSW) #115, they verified that resident #008 required this specified intervention, however, often refused. The PSW acknowledged that they should have documented in a progress note that the resident had refused the specified intervention.

During an interview with Registered Nurse (RN) #116, they indicated that if a resident refused a specified intervention, the PSW should have notified the registered staff.

b) A review of resident #017's plan of care, indicated an identified focus with a specified intervention.

On an identified date and time, the Inspector and PSW #115 observed resident #017 without the specified intervention. The PSW indicated that a PSW student had cared for the resident that day.

During an interview with the PSW Clinical Instructor, they verified that their students had cared for resident #017, and did not apply the specified intervention as they thought the resident no longer needed it.

During an interview with RN #116, they verified that resident #017 required this specified intervention.

c) A review of resident #016's plan of care, indicated an identified focus with a specified intervention.

On an identified date and time, the Inspector and PSW #115 observed resident #016 without the specified intervention.

During an interview with RN #116, they verified that resident #016 required the specified intervention.

During an interview with the Acting Director of Clinical Services (DOC), they had indicated that it was the expectation of the home that staff and students provided care to residents as specified in their plans of care. [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 resident #008, #016 and #017, is provided to the residents as specified in the plans, to be implemented voluntarily.

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.