Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 10, 2020	2020_745690_0004	023311-19	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

TRACY MUCHMAKER (690)

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): February 4-7, 2020.

The following intake was completed in this Critical Incident inspection:
-One log, which was a Critical Incident that the home submitted to the Director related to a missing resident.

Follow Up inspection #2020_745690_0003 was conducted concurrently with this Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the Inspector reviewed internal investigation notes, relevant resident health care records, licensee policies, procedures and programs and observed the provisions of care.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A Critical Incident (CI) report was submitted to the Director related to a missing resident. The CI report further indicated that resident #001 had a history of an identified responsive behaviour, had an identified intervention in place and that staff were to check that the identified intervention was in place at specified times.

A review of resident #001’s electronic care plan that was in place at the time of incident identified a focus for an identified responsive behaviour. The care plan included an identified intervention for safety and that staff were to check to ensure that the identified intervention was in place at specified times.

The Inspector reviewed documentation on Point of Care (POC) and identified a task that staff were to sign off to indicate that the identified intervention was in place. The task was to be completed at specified times each day. A further review of the documentation indicated that there was missing documentation for the checks of the identified intervention five times in the month of December 2019, four times in the month of January 2020, and two times in the month of February 2020. [s. 6. (9) 1.]

2. During an observation of resident #003, Inspector #690 identified that the resident had an identified intervention in place.

A review of resident #003’s electronic care plan that was in place at the time of the inspection, identified a focus for an identified responsive behaviour. The care plan indicated that the resident was to have the identified intervention in place for safety and that staff were to check to ensure that the identified intervention was in place at specified times.

The Inspector reviewed documentation on POC and identified a task that staff were to sign off to indicate that the identified intervention was in place. The task was to be completed at specified times each day. A further review of the documentation indicated that there was missing documentation for the checks of the identified intervention five times in the month of December 2019, four times in the month of January 2020, and once in the month of February 2020.

In separate interviews with Personal Support Worker (PSW) #105, and Registered Practical Nurse (RPN) #106, they indicated that resident #001, and resident #003 were

to have the identified intervention in place for safety and that PSW staff were to check that the identified intervention was in place at specified times. They further indicated that, at times, the PSW staff did not have time to document the check in POC.

In an interview with the Director of Care (DOC), they indicated that resident #001, and resident #003 had an identified intervention in place, and that PSW staff were to check that the identified interventions were in place at specified times and document the check on POC. Together, the Inspector and the DOC reviewed the documentation on POC for resident #001, and resident #003; and the DOC identified that there was missing documentation for the check of the identified intervention on a number of times in December 2019, January 2020, and February 2020. [s. 6. (9) 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 provision of the care set out in the plan of care is documented, to be implemented voluntarily.

Issued on this 11th day of February, 2020

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

Original report signed by the inspector.